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ADMINISTRATION'S MEDICARE CAPITATION INITIATIVES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

MARCH 10, 1988

Serial 100-62

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ADMINISTRATION'S MEDICARE CAPITATION INITIATIVES

THURSDAY, MARCH 10, 1988

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:11 a.m. in room 1100 of the Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY MARCH 4, 1988

PRESS RELEASE #20
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE ADMINISTRATION'S MEDICARE CAPITATION INITIATIVES TO BE HELD ON THURSDAY, MARCH 10, 1988

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on the Administration's Medicare capitation initiatives. The hearing will be held on Thursday, March 10, 1988, beginning at 10:00 a.m. in room 1100 Longworth House Office Building.

In announcing the hearing Chairman Stark said, "Medicare's implementation of its risk contracting program with Health Maintenance Organizations and other capitated health care delivery systems has not been without problems. Numerous questions regarding oversight by the Health Care Financing Administration, reimbursement, and quality assurance remain outstanding."

In addition, under new demonstration authority enacted in the 1987 reconciliation legislation, the Administration is proceeding to contract with a new type of capitated plan called Medicare Insured Groups.

With respect to this initiative, Chairman Stark said, "The new demonstration authority sets forth a series of requirements designed to deter abuse and I look forward to hearing about the Administration's plans for compliance with them."

The hearing will include testimony from Dr. William Roper, Administrator, Health Care Financing Administration (HCFA); the General Accounting Office; and other expert witnesses.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

Under the authority of section 1876 of the Social Security Act, Medicare contracts with health maintenance organizations (HMOs) and competitive medical plans for the provision of Medicare benefits to enrollees. Plans must agree to accept a prospectively determined payment from Medicare each month, equal to 95 percent of the average adjusted per capita cost (AAPCC) of Medicare benefits in the area, if they were purchased outside the HMO.

The plan develops a premium amount, called the adjusted community rate (ACR), for Medicare benefits based upon the premium charged for the same services provided to non-Medicare plan members. To the extent the ACR is less than 95 percent of the AAPCC, the plan must return the difference to Medicare beneficiaries in the form of additional benefits. Commonly, HMOs do so by reducing or eliminating Medicare's deductibles and copayments, or through limited drug or eyeglass benefits.

At present, 966,931 Medicare beneficiaries are enrolled in 134 risk contract health plans. In addition, there are 79 plans which contract with Medicare on a cost basis with an additional 800,000 beneficiaries enrolled.

The Omnibus Reconciliation Act of 1987 (OBRA 87) authorized HCFA to enter into contracts with a new type of plan termed employer-related or Medicare Insured Groups. OBRA 87 authorizes three such demonstrations which may involve no more than $600 million in Medicare funds. Under the demonstrations Medicare will contract with an employer to provide Medicare benefits to its own retirees. The employer will, in turn, contract with an HMO, a preferred provider organization, or an indemnity plan for the provision of health services. It is expected that the employer could generate savings through better coordination and management of Medicare and employer-supported supplemental health benefits.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday April 1, 1988, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW

Each statement presented for printing to the Committee by a witness any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below Any statement or exhibit not in compliance with these guidelines will **not** be printed but will be maintained in the Committee files for review and use by the Committee

1 All statements and any accompanying exhibits for printing must be typed in single space on legal size paper and may not exceed a total of 10 pages

2 Copies of whole documents submitted as exhibit material will not be accepted for printing Instead exhibit material should be referenced and quoted or paraphrased All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee

3 Statements must contain the name and capacity in which the witness will appear or for written comments the name and capacity of the person submitting the statement as well as any clients or persons or any organization for whom the witness appears or for whom the statement is submitted

4 A supplemental sheet must accompany each statement listing the name full address a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement This supplemental sheet will not be included in the printed record

The above restrictions and limitations apply only to material being submitted for printing Statements and exhibits or supplementary material submitted solely for distribution to the Members the press and public during the course of a public hearing may be submitted in other forms

Chairman **Stark**. The subcommittee will come to order. And I will ask unanimous consent that all witness statements appear in the record in their entirety, and that the witnesses be allowed to present their testimony in any manner they desire.

Today we are examining the status of the administration's Medicare capitation initiatives. We will focus on the Medicare risk contracting program and the Medicare insured group demonstration projects.

We are pleased to have with us Dr. William Roper, the Administrator of the Health Care Financing Administration. He brings expertise and information about the administration's initiatives, and his testimony should prove most helpful to the subcommittee..

Medicare's implementation of the risk contracting program with health maintenance organizations and other capitated health care delivery systems has not been without problems. Risk contracting is a good but not entirely proven strategy.

HCFA's ability to manage the program effectively is still in question. These are new programs. They lack the traditions which so many other programs have and the traditions which put constraints on programs.

The 29 HMO's affecting 80,000 Medicare beneficiaries terminated their contracts at the end of 1987. That could pose both a financial risk to taxpayers and/or a concern of access to health care for our beneficiaries.

I will look forward to GAO's review of HCFA's management. And to hearing from HCFA about efforts to improve their management capabilities and structure.

HCFA is now proceeding to expand its capitation program by establishing Medicare-insured group demonstration projects. In the face of the problems which HCFA has had in monitoring the existing program and program operators, I am concerned about this expansion to a new type of contract with non-health care providers.

Although our friends at Chrysler may make good cars, and John Deere used to make good tractors, I am not sure how good they are at providing health care. I am particularly concerned that these demonstrations not become a way to bailout employers unfunded health benefits liability, which are of a very indeterminate nature at this point, but many have estimated they could run into the hundreds of billions of dollars.

If savings are achieved through more effective management and coordination of benefits, the Government and the beneficiaries must be the primary recipients of those savings.

Turning over control of a public trust to a private concern is not a step to be taken lightly or hastily. Moreover, privatization of a public program as a policy for its own sake makes little or no sense to the Chair, and certainly has a high degree of political controversy.

The policy must provide substantial and significant benefits to the public program and its beneficiaries.

I remain skeptical that this test has been met in present capitation initiatives. I look forward to hearing from our witnesses on these and other matters.

Bill, welcome to the committee once again. And you can lead off. You will be followed by the GAO and witnesses from the Rand Corp.

I would encourage the members, if Dr. Roper doesn't mind, if they're unsure of something in his statement, or want to interject at any point, for our premier witness, let's be as informal as the witness or the members would like to be.

Are there any other opening statements? All right, please proceed in any manner you're comfortable.

[The statement of Chairman Stark follows:]

OPENING STATEMENT OF THE HONORABLE FORTNEY PETE STARK

Today the subcommittee will examine the status of the administration's Medicare capitation initiatives. We will focus on the Medicare risk contracting program and the Medicare insured group demonstration projects.

We are pleased once again to welcome Dr. William Roper, the Administrator of the Health Care Financing Administration. The expertise he brings and the information he can provide about the Administration's initiatives should prove most helpful to the subcommittee.

Medicare's implementation of the risk contracting program with health maintenance organizations and other capitated health care delivery systems has not been without problems. Risk contracting is a good, but not entirely proven, strategy.

Contracting with HMO's for Medicare benefits is a relatively recent phenomenon. Authorized by TEFRA in 1982, the program has grown rapidly but it is still relatively small.

There are 966,931 Medicare beneficiaries enrolled in 134 risk contract health plans. There are 79 additional plans which contract with Medicare on a cost basis with an additional 800,000 beneficiaries enrolled. HCFA has signed one contract to develop a Medicare insured group program.

HCFA's ability to manage the program effectively is still in question. Twenty-nine HMO's affecting 80,000 Medicare beneficiaries terminated their risk contracts at the end of 1987. Two HMO's in south Florida, IMC and Findlay, got into serious trouble, with IMC having to be totally reorganized by a new owner and Findlay having its risk contract terminated. In addition, the head of IMC was indicted for labor racketeering and left the country to avoid prosecution.

I will look forward to GAO's review of HCFA's management capabilities and to hearing from HCFA about efforts to improve those management capabilities.

Quality assurance in HMO's is also open to question. External review of HMO quality is just now getting off the ground. We need to know about the state of the art of HMO quality assurance plans and to understand how well the program is proceeding.

Reimbursement of risk contractors under the average adjusted per capita cost (AAPCC) system also raises a number of serious issues. Of course, the HMO's are concerned that payment is too low, particularly in rural areas. And it is certainly true that the county-by-county variations in payment appear to cause serious dislocations for both the HMO's and the beneficiaries.

However, there are serious questions on the other side related to the possibility that HMO's may be selecting their members from populations which are less likely to use health services. This would mean that the HMO's are overpaid. I hope that our witnesses will shed some light on the appropriateness and necessity of adjusting HMO payments to take geographic location, health status and other similar factors into account.

HCFA is now proceeding to expand its capitation program by establishing Medicare insured group demonstration projects. Under this proposal HCFA will contract with an employer to provide Medicare benefits to the employer's own retirees.

In the face of the problems which HCFA has had in monitoring the existing program, I have been very concerned about this expansion to a new type of contract with non-health care providers. Although Chrysler may make good cars and John Deere good tractors, I am not sure how good they are at providing health care.

I am particularly concerned that these demonstrations not become a way to bail out employers' unfunded health benefits liability. If savings are achieved through more effective management and coordination of benefits, the government and the beneficiaries must receive that benefit.

I would like to conclude by suggesting some general points to guide our discussions about the risk contracting program and other capitation initiatives.

Medicare is a public program which should benefit the public and not any particular private employer or provider. When things go wrong, beneficiaries do not, and will not, complain to private companies, even when the private company is at fault.

Turning over control of this public trust to a private concern is not a step to be taken lightly nor hastily. Moreover, privatization of a public program as a policy for its own sake makes little or no sense. The policy must provide substantial and significant benefits to the public program and its beneficiaries. I remain skeptical that this test has been met in these capitation initiatives.

I look forward to hearing from our witnesses on these and other matters.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. Roper. I would like to submit my statement for the record. But I have a few comments to start with.

I am here to talk about, as you say, Medicare's capitation initiatives. We in HCFA are describing our capitation initiatives under the rubric, the private health plan option for Medicare.

That is a term we came up with in response to the Secretary's request that we find a more informative expression than capitation, which we find either confuses or scares people. And so in my comments, I will be referring to the idea of a private health plan option as an alternative to traditional Medicare.

We in the administration and you in the Congress are pursuing a two-pronged approach to slowing the increase in Medicare expenditures. This is a point that I dwelt on in my appearance before you all last September 30 in talking about the rise in part B expenditures in Medicare.

There are two ways to go. The first is a prudent purchaser, prudent buyer, approach to health care services.

The other is to offer Medicare beneficiaries and providers a choice of private health plans. And let me draw the distinction between those two.

Under the prudent buyer reforms which we have undertaken, such as prospective payment for hospitals under Medicare, or the inherent reasonableness changes in the amount we pay certain physicians, the Federal Government is trying to use its market clout to purchase in a thoughtful way, or to pay less than we are paying in certain selected areas.

The implication is that we are getting a better deal for our money. But the further implication is that we are setting standards for the appropriate practice of medicine, and ever more intruding into decisionmaking about the practice of medicine.

We will be constraining the choices available to beneficiaries and providers, and we will be saying no. That's a point I made repeatedly in my September 30 appearance before you; in the process of saying no to things that doctors or others would want to do for their patients, controversy is inevitable, and we surely predict that.

We all need to be aware of what is coming as we increasingly delve into the questions about what is effective in the practice of medicine, and how better to shape decisions so that doctors do what's effective for patients.

The private health plan option, on the other hand, represents an entirely different approach. In exchange for assuming financial risk, private health plans, presently HMO's and what the law calls competitive medical plans, are given substantial latitude, though certainly not an entirely free hand, to determine who to pay, how much to pay, and what to pay for.

The private health plan option is based on certain fundamental principles. First, that these private plans are accountable for delivering quality health care to enrolled beneficiaries.

Second, that our role as government should be limited to the establishment of broad economic and quality standards to which we hold these plans accountable.

Third, that beneficiaries and providers should have a wide choice of options.

And fourth, that competition should be increased amongst these plans in the private sector.

Today about a million of the 16 million Medicare beneficiaries who have a choice to enroll in such a private plan, are enrolled.

We want to increase the number of beneficiaries who have the choice to enroll. Let me be clear: We do not have enrollment targets about how many actually will enroll. That is up to them to decide. We will trust their judgment.

Nobody is better able to decide for my father, who is a Medicare beneficiary, than he is. And I am willing to trust his judgment about where he goes for his health care services.

Private health plans are paid on a capitation basis, and they have strong incentives for efficiency, and we think over time, that's one of our best hopes in restraining the growth in Medicare expenditures.

As I said last September, when we talked about the increase in part B payments, and the resulting increase in the part B premium, and, as I suggested in my testimony, there are certain things we could do within the traditional Medicare program.

We could exercise continued restraint on the actual prices of the fees that we pay. You enacted such a restraint in the OBRA 1987 legislation.

We could further increase utilization review—I call that looking over doctors' shoulders. We're going to be doing more of that than ever before.

We could aggregate or bundle services together to pay for them, or direct beneficiaries to preferred provider networks. And we will be offering proposals in that regard shortly.

While we are developing these tools, we remain skeptical over whether in the long run this is going to be fully successful. We disagree with the assumption underlying these prudent buyer approaches that we can determine, centrally here in Washington, what the right way to practice medicine in all parts of the country is, and mandate that that be done in New York City or Minot, North Dakota, or anywhere else.

We also don't believe that either we in the executive or you in the legislative branch is capable of micromanaging the health care system, however thoughtful we all may be in that process.

The private health plan option is certainly not a panacea, but we think it is a better approach. It offers the opportunity for financial and medical decisions to be made at the local level. And the private plans offer beneficiaries either additional benefits or reduced out-of-pocket costs on the average of $200 per year per enrollee.

The private health plan offers maximum flexibility for providers to determine an individual course of treatment based on patient circumstances.

Let me emphasize that we are first and foremost interested in providing high quality services, in capitated plans or other plans.

HMO's have grown rapidly in the last decade, and are now an established part of the health care marketplace. Last year 29 million persons received their health care from HMO's.

That grew 22 percent in 1986, and 20 percent in 1987. Other managed care plans have also grown rapidly. Fifteen percent of employees use preferred provider organizations.

Those trends are going to continue. Some independent analysts predict that 50 percent of all employees will be enrolled in managed care plans in the early 1990's.

As I've said a million Medicare beneficiaries are enrolled in an HMO or a CMP. We think that's a large number, given the understandable reluctance of Medicare beneficiaries to change from established referral networks, doctors that they're currently going to, to these new private health plans.

During the last part of 1987, both Medicare and non-Medicare HMO enrollment began to slow. We think that is a natural consequence of the consolidation now occurring in the HMO industry. After initial very rapid growth in this sector, it is now slowing down. That should not be a surprise or a cause for concern. It is the natural process of an evolving industry.

We do believe that managed care is on the way to becoming the norm in American health care. What we are especially trying to do is to put into place a framework in Medicare for the over-65 population, so that people who are now 35 or 45 or 55, and are part of managed care plans, will be able to be in such plans once they retire and are eligible for Medicare.

Quality for all beneficiaries is my number one priority as Administrator of HCFA. Research has shown that HMO's offer the same or better care than is available in a fee-for-service system.

We are not saying that this decentralization through private plans means the Federal Government is going to turn its back or shirk its responsibility for assuring quality; quite the contrary.

Chairman STARK. What about access, Bill? If we turn our backs on those people who the HMO's would like to select against, is that not as tough a problem as quality? In other words, if you cannot get into the better program, because of a preexisting condition or age, don't we have to force access?

Dr. ROPER. Medicare HMO's have open enrollment periods, and they have to accept all comers in the Medicare population.

Chairman STARK. And don't we have to be careful that they don't subtly or subliminally select?

Dr. ROPER. Sure.

Chairman STARK. OK, now do open enrollment periods apply to any HMO that takes Medicare——

Dr. ROPER. Yes, they must take all comers.

Chairman **Stark**. They have to have an open enrollment periods periodically.

Dr. **Roper**. Yes, sir.

Chairman **Stark**. And advertise it?

Dr. **Roper**. I will get the particulars for you. But they do have to take folks who want to join their HMO.

[The following was subsequently received:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

SUBCOMMITTEE ON
RECEIVED
APR 12 1988
HEALTH

The Honorable Fortney H. (Pete) Stark
House of Representatives
Washington, D.C. 20515

Dear Mr. ~~Stark~~: Pete

I welcome the opportunity to provide you with additional information relating to the open enrollment requirements applicable to health maintenance organizations (HMOs) and competitive medical plans (CMPs) that contract with HCFA on a prepaid basis to provide covered items and services to Medicare beneficiaries.

As I indicated at the Ways and Means hearing on March 10 on the Administration's Medicare capitation initiatives, HMOs and CMPs that contract with HCFA under section 1876 of the Medicare statute are required by Medicare statute and regulations to hold a 30-day open enrollment period at least once each year. The HMO/CMP must accept new members on a "first-come, first-served" basis, and may not refuse to enroll members for reasons of health status.

The HMO/CMP must appropriately notify the general public of its enrollment period, and must provide to prospective enrollees adequate written descriptions of the organization's rules, procedures, benefits, premiums, services, and other information necessary for beneficiaries to make an informed decision about enrollment.

Our information indicates that the Kaiser Foundation health plan serving Walnut Creek, California denied enrollment in the plan to your mother because of her smoking history. However, this Kaiser plan is not an HMO or CMP which has a contract with HCFA under section 1876 of the Medicare statute, but is what is known as a Health Care Prepayment Plan (HCPP). HCPPs are permitted under section 1833(a)(1) of the Medicare statute to receive reasonable cost in lieu of reasonable charge reimbursement for a range of Medicare Part B (physician) services.

HCPPs differ from HMOs and CMPs with Medicare contracts under section 1876 of the Act in that HCPPs do not provide Part A (hospital) services, and they may offer less than the full range of Part B benefits. HCPPs are not subject to the section 1876 requirements, and the rules relating to open enrollment, health screening, marketing and enrollee appeal rights therefore do not apply to them.

For your information, the only Kaiser health plan in California that has a section 1876 contract is the Kaiser Foundation Health Plan, Inc., Southern California Region. This plan has two risk contracts, one in Southern California and one in Bakersfield.

The only section 1876 risk contractor whose service area includes Walnut Creek, California, is the Bay Pacific Health Plan. The plan's next open enrollment period is scheduled to occur in December 1988. Because it has reached its enrollment capacity it is not currently accepting new enrollments.

There is also a Medicare cost-reimbursed contractor serving Walnut Creek, the Contra Costa County Health Plan, which is currently accepting enrollees. Contra Costa has an HMO contract under section 1876 and is meeting the open enrollment requirement by having a continuous open enrollment. However, the plan is near the maximum allowable 50 percent level of Medicare/Medicaid enrollees, and is prohibited by statute from exceeding the 50 percent level.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Bill

William L. Roper, M.D.
Administrator

Medicare has three types of contracts with HMOs:

1) A "Health Care Prepayment Plan" (HCPP), which covers only part B services. Medicare currently has 33 of these contracts.

2) A TEFRA cost contract which covers part A and part B services. The plan does not assume financial risk and beneficiaries are not required to receive all of their services from the plan. Medicare currently has 35 of these contracts.

3) A TEFRA risk contract where the plan assumes financial risk for the full Medicare benefit package and beneficiaries must receive all of their care from the plan unless it is an emergency or urgently needed service. Medicare currently has 135 of these contracts.

HCPPs do not have to meet open enrollment requirements and are permitted to health screen.

HMOs with TEFRA cost and risk contracts are required to meet open enrollment requirements. We require that there be a continuous 30 day open enrollment during which Medicare beneficiaries are accepted in the order that their applications are received until enrollment capacity is reached. The plans may keep a waiting list of applications that exceed their capacity limits and enroll them in chronological order as vacancies occur.

The plans are not allowed to screen for health condition as an application requirement. Plans that violate this requirement are subject to civil monetary penalties.

Plans may refuse to enroll an otherwise eligible individual if enrollment would mean that more than 50 percent of the total enrollees were Medicare or Medicaid beneficiaries. In addition, the Secretary may approve a HMO selection policy in the following circumstances:

- If membership would not be representative of the population in its enrollment area;
- If enrollment would cause the HMO to be unable to provide needed health services;
- If enrollment would exceed the HMO's capacity;
- For a risk HMO, if enrollment would pose an immediate threat to the HMO's financial viability.

The HMO must notify the general public of its open enrollment period through appropriate advertising in newspapers, television, or radio. They must also provide prospective enrollees with written descriptions of the organization's benefits, rules, premiums, and other information necessary for beneficiaries to make informed decisions about enrollment.

Dr. Roper. We have developed a coordinated strategy to monitor these private plans, based on a variety of inputs of information. I think that the contracts that we now have in place for PRO and quality review organization review of HMO's and CMP's are going to serve well in the oversight of such plans.

We have had some problems in implementing this review, largely by the peer review organizations, of Medicare HMO's. One of the problems we've had is getting information to the peer review organizations on just which Medicare beneficiaries were hospitalized.

We are solving this problem by mandating that hospitals report all HMO hospital admissions directly to the intermediaries so that this information can be followed up by the peer review organizations, the quality review organizations.

This review will also encompass review of ambulatory care, and we and the PRO's are developing plans for just how to undertake such an ambulatory care review.

We are conducting research mandated by the Congress to identify organizational arrangements or financial incentives that might pose a problem for beneficiaries. And the Department, as you well know, owes you a report on that subject shortly.

An important issue in assuring the growth and success of private health plans is the development of a fair payment mechanism. We are authorized to set HMO rates prospectively at 95 percent of the adjusted average per capita cost, the so-called AAPCC.

While this method has generally worked, the method can and should be refined. We have taken a number of steps, including convening an expert task force—chaired, by the way, by Joe Newhouse, who is going to talk to you later this morning—to look at how to improve the AAPCC.

We have also developed at their suggestion a series of demonstrations on alternative adjustment methodology called the diagnostic cost group methodology for AAPCC adjustment, and we plan to test that methodology later this year in a number of demonstrations.

We are also developing the Medicare insured group demonstration projects which you authorized in last year's reconciliation act.

We are currently in the process of resolving issues raised by two applicants. And we will keep you and GAO fully informed of the progress of these projects.

We are also looking at a number of other research issues in connection with payments.

In conclusion, let me say that private health plans offer an important alternative for beneficiaries who seek a more flexible health care delivery system that can reduce out-of-pocket costs, and offer increased benefits and high quality care.

They also offer greater flexibility to doctors, hospitals and other providers. We seek to give a fair choice to all Medicare beneficiaries, and believe that they will make the right choice for themselves.

Thank you very much. I would be glad to respond to your questions.

[The statement of Dr. Roper follows:]

STATEMENT OF
WILLIAM L. ROPER
ADMINISTRATOR
HEALTH CARE FINANCING AMDINISTRATION

I AM PLEASED TO BE HERE TODAY TO DISCUSS MEDICARE CAPITATION INITIATIVES.

MEDICARE'S TWO-PRONGED STRATEGY

THE ADMINISTRATION, IN CONJUNCTION WITH THE CONGRESS, HAS ADOPTED A TWO-PRONGED APPROACH TO SLOWING THE INCREASE IN MEDICARE EXPENDITURES. THE FIRST STRATEGY IS TO ASSURE THAT THE FEDERAL GOVERNMENT, AS THE INSURER FOR THE MEDICARE POPULATION, IS A "PRUDENT PURCHASER" OF HEALTH CARE SERVICES. THE SECOND APPROACH IS TO OFFER MEDICARE BENEFICIARIES AND HEALTH-CARE PROVIDERS THE OPTION OF PARTICIPATING IN MEDICARE THROUGH PRIVATE HEALTH PLANS, IN LIEU OF THE TRADITIONAL GOVERNMENT-MANAGED INSURANCE PLAN. WE CALL THIS SECOND ALTERNATIVE OUR PRIVATE HEALTH PLAN OPTION (PHPO).

YOU ARE VERY FAMILIAR WITH THE "PRUDENT BUYER" APPROACH. EACH YEAR, AS PART OF THE RECONCILIATION PROCESS, A NEW LIST OF INCREMENTAL REFORMS IS MANDATED TO SLOW THE INCREASE IN MEDICARE EXPENDITURES. EXAMPLES INCLUDE THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITALS, THE PARTICIPATING PHYSICIAN PROGRAM, "INHERENT REASONABLENESS" LIMITS ON PHYSICIAN FEES, AND PEER REVIEW ORGANIZATIONS (PROS).

UNDER "PRUDENT BUYER" REFORMS, THE FEDERAL GOVERNMENT REMAINS AS THE INSURER RESPONSIBLE FOR ASSUMING FINANCIAL RISK. TO CONTROL THIS RISK -- FOR THE BENEFIT OF BOTH MEDICARE BENEFICIARIES AND THE TAXPAYERS, WE HAVE ADOPTED AN INCREASINGLY PRESCRIPTIVE SET OF RULES ON HOW TO PAY INDIVIDUAL PROVIDERS. THROUGH PROS AND MEDICARE'S INTERMEDIARIES AND CARRIERS, WE ALSO SET STANDARDS ON APPROPRIATE MEDICAL PRACTICE -- FOR EXAMPLE, WHEN A PATIENT SHOULD BE TREATED AS AN OUTPATIENT, NOT AN INPATIENT. THESE RULES CONSTRICT THE RANGE OF CHOICE FOR BENEFICIARIES AND PROVIDERS. IT IS ONLY BY SAYING "NO" THAT WE SAVE MONEY.

THE PHPO REPRESENTS A FUNDAMENTALLY DIFFERENT APPROACH TO COST CONTAINMENT. UNDER PHPO, THE GOVERNMENT SHIFTS THE FINANCIAL RISK TO PRIVATE HEALTH PLANS. IN EXCHANGE FOR ASSUMING THAT RISK, THEY ARE GIVEN SUBSTANTIAL LATITUDE, THOUGH NOT AN ENTIRELY FREE HAND, TO DETERMINE WHO TO PAY, HOW MUCH TO PAY, AND WHAT TO PAY FOR. PRIVATE HEALTH PLANS CURRENTLY AVAILABLE UNDER MEDICARE INCLUDE HEALTH MAINTENANCE ORGANIZATIONS (HMOS) AND COMPETITIVE MEDICAL PLANS (CMPS).

THE PHPO IS BASED ON SEVERAL IMPORTANT PRINCIPLES:

FIRST, PRIVATE HEALTH PLANS ARE ACCOUNTABLE FOR DELIVERING A SPECIFIC PRODUCT, THAT IS, QUALITY HEALTH CARE.

SECOND, THE GOVERNMENT'S ROLE SHOULD BE LIMITED TO THE ESTABLISHMENT OF BROAD ECONOMIC AND QUALITY STANDARDS. DECISIONS ON HOW TO MEET THESE STANDARDS SHOULD BE LEFT, SUBJECT TO BROAD CONSTRAINTS, TO LOCAL HEALTH CARE PROVIDERS.

THIRD, BENEFICIARIES AND PROVIDERS SHOULD BE ABLE TO CHOOSE A HEALTH CARE DELIVERY SYSTEM THAT MEETS THEIR INDIVIDUAL NEEDS FROM A WIDE RANGE OF OPTIONS.

FOURTH, COMPETITION IN THE MARKETPLACE SHOULD BE INCREASED.

CONTRARY TO SOME REPORTS, OUR GOAL IS NOT TO REQUIRE MEDICARE BENEFICIARIES TO ENROLL IN PRIVATE HEALTH PLANS. WE HAVE NO ENROLLMENT TARGETS. RATHER, OUR GOAL IS TO GIVE BOTH BENEFICIARIES AND PROVIDERS AN ALTERNATIVE TO TRADITIONAL MEDICARE. TO PUT IT ANOTHER WAY, WE WANT TO OFFER PRIVATE HEALTH PLANS A FAIR MARKET TEST. IF PRIVATE HEALTH PLANS OFFER A

QUALITY, EFFICIENTLY-MANAGED SERVICE, THEY WILL GROW.

TODAY ALMOST ONE MILLION MEDICARE BENEFICIARIES HAVE ENROLLED IN HMOS AND CMPS. 16 MILLION MEDICARE BENEFICIARIES HAVE A CHOICE OF ENROLLING IN A PRIVATE HEALTH PLAN. WE BELIEVE THAT MORE BENEFICIARIES SHOULD HAVE THIS CHOICE AND WE ARE ANXIOUS, THEREFORE, TO EXPAND THE NUMBER AND RANGE OF PLANS AVAILABLE.

RATIONALE FOR THE PRIVATE HEALTH PLAN OPTION

BECAUSE THE PLANS PARTICIPATING IN PHPO ARE PAID ON A CAPITATION BASIS, THEY HAVE STRONG INCENTIVES FOR EFFICIENCY. WE HOPE, OF COURSE, THAT THESE INCENTIVES WILL HELP SLOW THE INCREASE IN MEDICARE EXPENDITURES, AT LEAST IN THE LONG RUN. JUDGING BY THE RECORD OF OUR PART B "PRUDENT PURCHASER" EFFORTS, WE NEED THE HELP.

LAST SEPTEMBER, I APPEARED BEFORE THIS COMMITTEE AND REPORTED THAT MEDICARE PART B PAYMENTS HAD INCREASED BEYOND OUR PREDICTIONS, LARGELY AS A RESULT OF THE INCREASE IN VOLUME AND INTENSITY OF SERVICES, ESPECIALLY PHYSICIAN SERVICES. AS A RESULT OF THESE INCREASED COSTS, IT WAS NECESSARY TO INCREASE THE PREMIUM CHARGED TO BENEFICIARIES BY 38.5 PERCENT.

LAST FALL, I ALSO DESCRIBED THE RANGE OF OPTIONS AVAILABLE TO US TO CONTROL THIS GROWTH UNDER TRADITIONAL MEDICARE. THEY WERE:

- CONTINUED RESTRAINT ON FEES, BOTH ACROSS-THE-BOARD AND "INHERENT REASONABLENESS" LIMITS

- INCREASED UTILIZATION REVIEW THROUGH PROS AND MEDICARE CARRIERS

- BUNDLING OF SERVICES COMBINED WITH PAYMENT BASED ON AVERAGE COSTS, (E.G. RAP)

- DIRECT BENEFICIARIES TO PREFERRED PROVIDER NETWORKS.

WE HAVE INVESTED, AND WILL CONTINUE TO INVEST, CONSIDERABLE EFFORT IN DEVELOPING THESE TOOLS, YET WE REMAIN SKEPTICAL ABOUT THEIR EFFECTIVENESS IN THE LONG RUN. WE FEAR, MOREOVER, THAT THESE EFFORTS WILL LEAD YOU AND US INTO EVER MORE PRESCRIPTIVE RULES GOVERNING MEDICAL PRACTICE -- AND INTO EVER MORE UNTENABLE POSITIONS.

THESE "PRUDENT BUYER" REFORMS ARE BASED ON AN IMPLICIT ASSUMPTION THAT THERE IS A "RIGHT" WAY TO DELIVER AND PAY FOR MEDICARE SERVICES. THEY ASSUME, MOREOVER, THAT THE GOVERNMENT CAN DETERMINE THE RIGHT ANSWER AND APPLY IT EFFECTIVELY ACROSS A DIVERSE AND DYNAMIC HEALTH CARE SYSTEM. WE DISAGREE WITH THAT PREMISE. WE DO NOT BELIEVE THAT THERE ARE UNIFORM RULES THAT CAN APPLY TO MEDICAL AND ECONOMIC CIRCUMSTANCES IN NEW YORK CITY AND MINOT, NORTH DAKOTA. AND EVEN IF THERE WERE, WE DO NOT BELIEVE THAT THE ORGANIZATIONAL, LEGAL, AND POLITICAL CONSTRAINTS ON EXECUTIVE AND LEGISLATIVE DECISIONMAKING WOULD PERMIT US TO ADMINISTER SUCH DETAILED RULES EFFECTIVELY. IN SHORT, YOUR INSTITUTION AND MINE ARE INCAPABLE OF MICRO-MANAGING THE HEALTH CARE SYSTEM.

THE PRIVATE HEALTH PLAN OPTION, WHILE HARDLY A PANACEA, IS A BETTER APPROACH. IT OFFERS AN OPPORTUNITY FOR FINANCIAL DECISIONS AND MEDICAL DECISIONS TO BE MADE AT THE LOCAL LEVEL WHERE THEY CAN REFLECT LOCAL ECONOMIC CONDITIONS, SUCH AS WAGE LEVELS AND SUPPLY OF PROVIDERS AND PRACTICE PATTERNS.

MORE IMPORTANTLY, AND USUALLY OVERLOOKED, IS THAT THE FACT THAT THE PHPO OFFERS PROVIDERS AND THEIR PATIENTS THE MAXIMUM FLEXIBILITY TO DETERMINE THE BEST COURSE OF TREATMENT BASED ON THE PERSONAL PREFERENCES AND CIRCUMSTANCES OF INDIVIDUAL PATIENTS, RATHER THAN THE COURSE OF TREATMENT THAT WILL MAXIMIZE

FEDERAL REIMBURSEMENT. BECAUSE THEY HAVE THE FLEXIBILITY TO RESPOND TO LOCAL MARKET CONDITIONS AND NEEDS -- AND THE INCENTIVE TO BE EFFICIENT, PRIVATE HEALTH PLANS CAN ALSO OFFER REDUCED OUT-OF-POCKET COSTS AND PROVIDE EXTRA BENEFITS NOT NORMALLY COVERED UNDER THE TRADITIONAL MEDICARE PROGRAM. PREVENTIVE HEALTH SERVICES ARE BUT ONE EXAMPLE. TODAY, THE AVERAGE HMO THAT CONTRACTS WITH MEDICARE PROVIDES ADDITIONAL BENEFITS OR REDUCED COST-SHARING EQUAL TO ALMOST $200 PER YEAR.

PRIVATE HEALTH PLANS ALSO PROVIDE RELIEF FOR PROVIDERS FROM INCREASINGLY COMPLEX REGULATIONS PRODUCED DURING OUR ANNUAL RITE OF "RECONCILIATION". FRANKLY, NEITHER YOU NOR WE UNDERSTAND THE CONSEQUENCES OF THESE RULES VERY WELL. BUT WE IMPOSE THEM AS THOUGH THEY WERE TESTED AND PROVEN. THEN WE TURN AROUND AND CHANGE THE RULES AGAIN BEFORE ANYBODY FIGURED OUT LAST YEAR'S RULES. THIS FITFUL PROCESS IS THE RESULT OF TRYING TO MICRO-MANAGE WITH INSTITUTIONS ILL-SUITED TO THE TASK. EVERY NEW RULE SPAWNS A NEW PROBLEM, BECAUSE NATIONAL RULES INEVITABLY CAUSE INEQUITIES WHEN APPLIED TO DIVERSE CIRCUMSTANCES. THOSE INEQUITIES SPAWN NEW RULES, AND SO ON.

LET ME RE-EMPHASIZE: PHPO IS NOT A PANACEA. BUT IT DOES ESTABLISH A BETTER FRAMEWORK FOR DECISIONMAKING. INSTEAD OF WRITING DETAILED RULES ON HOW EVERY INDIVIDUAL PROVIDER SHOULD BE PAID, WE CAN LEAVE THAT TO LOCAL NEGOTIATIONS AMONG PRIVATE PARTIES. MEANWHILE, WE IN THE FEDERAL GOVERNMENT CAN FOCUS ON THE FUNDAMENTAL RULES GOVERNING COMPETITION AMONG PRIVATE HEALTH PLANS, ESPECIALLY RULES TO ASSURE QUALITY SERVICE TO MEDICARE BENEFICIARIES.

LET ME ALSO EMPHASIZE THAT PHPO IS ENTIRELY CONSISTENT WITH PROVIDING HIGH QUALITY SERVICES. INDEED, DECENTRALIZATION UNDER THE FRAMEWORK OF CAPITATION ACTUALLY PROMOTES QUALITY. UNDER THE PHPO, A SINGLE ORGANIZATION ASSUMES BOTH THE FINANCIAL RISK AND MEDICAL RESPONSIBILITY FOR PROVIDING THE FULL RANGE OF SERVICES. FEE-FOR-SERVICE PAYMENT, IN CONTRAST, FRAGMENTS BOTH FINANCIAL AND MEDICAL RESPONSIBILITY. HOLDING A SINGLE ORGANIZATION ACCOUNTABLE FOR THE FULL RANGE OF SERVICES SHOULD FACILITATE THE DEVELOPMENT OF MEANINGFUL OUTCOME MEASURES OF QUALITY.

TRENDS

HMOS HAVE GROWN RAPIDLY DURING THE LAST DECADE AND ARE NOW AN ESTABLISHED PART OF THE HEALTH CARE MARKETPLACE. IN 1987, 29 MILLION PERSONS RECEIVED THEIR HEALTH CARE FROM HMOS. TOTAL ENROLLMENT INCREASED 22 PERCENT DURING 1986 AND 20 PERCENT DURING 1987.

OTHER MANAGED CARE PLANS HAVE ALSO GROWN RAPIDLY. FOR EXAMPLE, EMPLOYERS SEEKING TO REDUCE HEALTH CARE COSTS ARE ENCOURAGING EMPLOYEES TO CONSIDER PREFERRED PROVIDER ORGANIZATIONS AS WELL AS HMOS. PRESENTLY, 19 PERCENT OF ELIGIBLE EMPLOYEES ARE ENROLLED IN HMOS AND AN ADDITIONAL 15 PERCENT USE PPOS.

THESE TRENDS ARE EXPECTED TO CONTINUE. FOR EXAMPLE, XEROX RECENTLY ANNOUNCED THAT PARTICIPATION IN A MANAGED CARE SYSTEM WILL BE MANDATORY FOR ALL EMPLOYEES BY 1990. ROBERTSON, COLMAN AND STEPHENS, INDEPENDENT ANALYSTS, PREDICT THAT 50 PERCENT OF ALL EMPLOYEES WILL BE ENROLLED IN A MANAGED CARE PLAN BY THE EARLY 1990S.

TEFRA, ENACTED IN 1982, FIRST OFFERED MEDICARE BENEFICIARIES THE SAME OPPORTUNITY TO ENROLL IN AN HMO AS WAS AVAILABLE TO EMPLOYEES. SINCE IMPLEMENTATION IN 1985, ALMOST 1 MILLION BENEFICIARIES HAVE ENROLLED IN AN HMO OR CMP. THIS ENROLLMENT IS IMPRESSIVE GIVEN THE UNDERSTANDABLE RELUCTANCE AMONG SENIOR CITIZENS TO BREAK LONGSTANDING PHYSICIAN RELATIONSHIPS, PARTICULARLY IF UNDER ACTIVE TREATMENT.

DURING THE LAST HALF OF 1987, BOTH MEDICARE AND NON-MEDICARE HMO ENROLLMENT BEGAN TO SLOW. A NUMBER OF PLANS ENCOUNTERED

FINANCIAL PROBLEMS, ESPECIALLY PLANS WITH ENROLLMENT UNDER 50,000. 29 PLANS WITH 8 PERCENT OF MEDICARE ENROLLMENT CHOSE NOT TO RENEW THEIR TEFRA CONTRACTS THIS YEAR. PROBLEMS STEMMED FROM DIFFICULTIES MANAGING GROWTH, TO A SHAKEOUT IN THE MARKETPLACE RESULTING IN MERGERS AND CONSOLIDATIONS, TO PROBLEMS RESULTING FROM POOR MANAGEMENT SYSTEMS.

A SLOWDOWN IN HMO GROWTH WAS PROBABLY INEVITABLE. A PERIOD OF CONSOLIDATION MAY WELL BE NEEDED. BUT WE BELIEVE MANAGED CARE IS ON THE WAY TO BECOMING THE NORM IN AMERICAN HEALTH CARE. THE GROWTH WILL BE FASTEST AMONG THE UNDER-65 POPULATION, BUT TODAY'S 35, 45, AND 55 YEAR OLDS ENROLLED IN MANAGED CARE PLANS WILL SOME DAY AGE INTO MEDICARE. PHPO IS OUR EFFORT TO ESTABLISH A MEDICARE FRAMEWORK TO ACCOMMODATE THIS FUNDAMENTAL CHANGE IN THE U.S. HEALTH CARE SYSTEM.

QUALITY

MY NUMBER ONE PRIORITY AS ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION IS TO ASSURE THAT BENEFICIARIES WILL RECEIVE HIGH QUALITY CARE, WHETHER THEY CHOOSE THE FEE-FOR-SERVICE SYSTEM OR THE PRIVATE HEALTH PLAN OPTION.

RESEARCH HAS SHOWN THAT HMOS OFFER THE SAME OR BETTER CARE THAN IS AVAILABLE IN THE FEE-FOR-SERVICE SYSTEM. FOR EXAMPLE, DR. HAL LUFT HAS REVIEWED THE LITERATURE ON QUALITY IN HMOS AND CONCLUDED THAT QUALITY IS, ON AVERAGE, AT LEAST AS GOOD AS IN THE FEE-FOR-SERVICE SECTOR. THE RAND CORPORATION, TO CITE ANOTHER EXAMPLE, STUDIED ONE HMO (GROUP HEALTH COOPERATIVE OF PUGET SOUND) IN DEPTH AND FOUND THAT THE HMO REDUCED TOTAL HEALTH EXPENDITURES BY 28 PERCENT COMPARED TO A COMPREHENSIVE, FEE-FOR-SERVICE PLAN. THE SAVINGS WERE ACHIEVED, MOREOVER WITH "NO OBSERVABLE ADVERSE EFFECTS ON HEALTH". A SIGNIFICANT PORTION OF THE HMO'S SAVINGS CAME FROM REDUCING "DISCRETIONARY SURGERY".

WE SUPPORT THE PHPO CONCEPT BECAUSE IT ESTABLISHES A FRAMEWORK FOR DECENTRALIZING KEY DECISIONS ABOUT HOW TO PAY PROVIDERS AND DECISIONS ABOUT APPROPRIATE PRACTICE IN INDIVIDUAL CASES. LET ME EMPHASIZE HOWEVER, THAT DECENTRALIZATION DOES NOT MEAN THAT THE FEDERAL GOVERNMENT SHOULD SHIRK ITS RESPONSIBILITY FOR ASSURING QUALITY. WE INTEND TO CONTINUE AN ACTIVE ROLE IN ASSURING THAT PRIVATE HEALTH PLANS MEET THE HIGHEST STANDARDS OF CARE.

WE HAVE DEVELOPED A COORDINATED MONITORING STRATEGY THAT IS NOW IN PLACE TO MONITOR HMOS AND CMPS. THIS STRATEGY IDENTIFIES PROBLEMS BY INTEGRATING DATA FROM A VARIETY OF INFORMATION SOURCES INCLUDING MANAGEMENT REVIEWS, FINANCIAL REPORTS, SPECIAL STUDIES, QUALITY REVIEWS, AND BENEFICIARY INFORMATION. FOR EXAMPLE, OUR NEW SYSTEM TO TRACK BENEFICIARY COMPLAINTS WILL BE COMBINED WITH FINDINGS OF OUR ON-SITE REVIEW TEAMS, AND PRO/QRO (PEER REVIEW ORGANIZATION/QUALITY REVIEW ORGANIZATION) REVIEW. RESULTS WILL BE USED TO PROVIDE TECHNICAL ASSISTANCE TO PROBLEM PLANS. WE WILL ALSO USE THIS INFORMATION WHEN WE MAKE DECISIONS ON CONTRACT RENEWALS.

I AM ALSO PLEASED TO REPORT THAT CONTRACTS PROVIDING FOR PRO/QRO REVIEW OF HMOS AND CMPS ARE NOW IN PLACE. OUR CONTRACTORS ARE REQUIRED TO REVIEW INPATIENT AND OUTPATIENT CARE PROVIDED TO A SAMPLE OF ALL MEDICARE BENEFICIARIES WHO HAVE ENROLLED IN A HMO. THE SCOPE OF WORK REQUIRES PROS/QROS TO REVIEW A SAMPLE OF CASES ADMITTED TO THE HOSPITAL FOR 13 SPECIFIC CONDITIONS CHOSEN BECAUSE OF THEIR POSSIBLE ASSOCIATION WITH SUBSTANDARD AMBULATORY CARE. IN ADDITION, THE PRO/QRO REVIEW INCLUDES CASES DISCHARGED FROM THE HOSPITAL, DEATHS, CASES READMITTED TO THE HOSPITAL WITHIN 31 DAYS AND CERTAIN TRANSFERS BETWEEN HOSPITALS.

IMPLEMENTATION OF PRO/QRO REVIEW HAS BEEN HAMPERED BY A PROBLEM IN IDENTIFYING HMO ENROLLEES WHO HAVE BEEN HOSPITALIZED. MANY HMOS HAVE NOT SUBMITTED THE REQUIRED HOSPITAL ADMISSION FORMS TO INTERMEDIARIES. TO BREAK THIS LOGJAM, WE ARE MANDATING THAT HOSPITALS REPORT ALL HMO HOSPITAL ADMISSIONS DIRECTLY TO

INTERMEDIARIES. THIS SOLUTION WILL ASSURE THAT TIMELY AND ACCURATE DATA IS REPORTED. HOSPITALS, AS YOU KNOW, ROUTINELY REPORT THIS INFORMATION FOR ALL FEE-FOR-SERVICE HOSPITAL ADMISSIONS, SO THE ADDED BURDEN SHOULD BE MINIMAL. MOREOVER, HOSPITAL REPORTING OF THESE DATA WILL ASSURE THAT FUTURE RELEASES OF HOSPITAL MORTALITY STATISTICS INCLUDE ALL MEDICARE PATIENTS, INCLUDING HMO PATIENTS.

PRO/QRO REVIEW WILL ALSO ENCOMPASS REVIEW OF AMBULATORY CARE. DURING THIS FIRST CONTRACT, WE HAVE REQUIRED PROS/QROS TO SUBMIT FOCUSED AMBULATORY REVIEW PLANS 6 MONTHS AFTER THE EFFECTIVE DATE OF THEIR CONTRACTS. WE ARE CURRENTLY REVIEWING THESE PLANS. BASED ON RECOMMENDATIONS FROM THE INDUSTRY, WE HAVE ALSO DEVELOPED AN AMBULATORY REVIEW PLAN THAT WILL BE MANDATED FOR PROS/QROS WHO FAIL TO SUBMIT AN ACCEPTABLE PLAN.

WE CONTINUE TO BELIEVE THAT AT LEAST 50 PERCENT OF THE ENROLLEES IN HMOS SHOULD BE NON-MEDICARE OR MEDICAID RECIPIENTS. ALTHOUGH ENROLLMENT RESTRICTIONS SHOULD NOT BE THE SOLE GUARANTY OF QUALITY, THEY ARE AN IMPORTANT SCREENING TOOL. BEFORE HMOS MAY ENROLL MEDICARE BENEFICIARIES, THEY SHOULD PROVE THEMSELVES IN THE PRIVATE MARKET.

WE EXPECT THAT THESE QUALITY REVIEW MECHANISMS WILL DETECT AND RESOLVE PROBLEMS WITH UNACCEPTABLE CARE IN PRIVATE HEALTH PLANS. BUT WE ARE ALSO CONDUCTING RESEARCH MANDATED BY CONGRESS TO IDENTIFY ORGANIZATIONAL ARRANGEMENTS OR FINANCIAL INCENTIVES THAT MAY LEAD SYSTEMATICALLY TO INAPPROPRIATE OR INSUFFICIENT SERVICE. WHILE IN GENERAL WE DO NOT BELIEVE THAT GOOD PHYSICIANS WILL TURN BAD BECAUSE OF A FINANCIAL INCENTIVE, IT IS IMPORTANT TO IDENTIFY ANY NEGATIVE IMPACT THAT MAY OCCUR AND DEVELOP SAFEGUARDS IF NEEDED.

PAYMENT MECHANISMS

AN IMPORTANT ISSUE IN ASSURING THE GROWTH AND SUCCESS OF PRIVATE HEALTH PLANS IS THE DEVELOPMENT OF A FAIR PAYMENT MECHANISM.

TEFRA AUTHORIZED MEDICARE TO SET HMO RATES PROSPECTIVELY AT 95 PERCENT OF THE AAPCC (ADJUSTED AVERAGE PER CAPITA COST). THIS IS HCFA'S ACTUARIAL ESTIMATE OF WHAT IT WOULD HAVE COST TO PROVIDE MEDICARE-COVERED SERVICES UNDER FEE-FOR-SERVICE IN THE SAME GEOGRAPHIC AREA TO A DEMOGRAPHICALLY SIMILAR GROUP OF BENEFICIARIES. THE AAPCC PAYMENT METHODOLOGY CALCULATES AN INDIVIDUAL PAYMENT RATE FOR EACH ENROLLEE BASED ON AGE, SEX, COUNTY OF RESIDENCE, WELFARE AND INSTITUTIONAL STATUS. WHILE THIS METHOD HAS GENERALLY WORKED, THE PAYMENT METHOD CAN, AND SHOULD, BE REFINED.

WE HAVE UNDERTAKEN A NUMBER OF EFFORTS TO IMPROVE THE AAPCC METHODOLOGY. THE FIRST STEP HAS BEEN TO CONVENE AN EXPERT TASK FORCE, CHAIRED BY JOSEPH NEWHOUSE OF THE RAND CORPORATION, TO IDENTIFY PROBLEMS WITH THE DATA AND METHODOLOGY WE CURRENTLY USE. ONE OF THE PROBLEMS POINTED OUT BY THIS GROUP IS THAT THE CURRENT METHOD OF ADJUSTING FOR DEMOGRAPHICS, INSTITUTIONALIZATION, AND WELFARE STATUS DOES NOT FULLY REFLECT VARIATIONS IN ENROLLEE HEALTH STATUS. THROUGH OUR RESEARCH PROGRAM WE HAVE DEVELOPED AN ALTERNATIVE METHODOLOGY TO ADJUST PAYMENTS BASED ON THE PRIOR HOSPITAL UTILIZATION OF THE HMO ENROLLEES. THIS METHOD IS KNOWN AS THE DIAGNOSTIC COST GROUPS, OR DCGS. WE WILL BE TESTING PAYMENT BY DCGS IN SOME DEMONSTRATION SITES THIS YEAR.

ANOTHER APPROACH TO IMPROVING THE AAPCC METHODOLOGY IS TO MOVE FROM INDIVIDUAL CONTRACTS TO GROUP-BASED CONTRACTS, AS IN THE MEDICARE INSURED GROUP (MIG) DEMONSTRATION PROJECTS AUTHORIZED BY LAST YEAR'S RECONCILIATION ACT. IT IS EASIER TO PREDICT THE HEALTH CARE EXPENSES OF A GROUP OF MEDICARE BENEFICIARIES THAN ON AN INDIVIDUAL ENROLLEE BASIS. THUS A CAPITATION RATE INCORPORATING THE PRIOR EXPERIENCE OF A GROUP MAY WELL BE MORE ACCURATE. WE HAVE ENTERED INTO AGREEMENTS WITH TWO MIG APPLICANTS, AMALGAMATED LIFE INSURANCE COMPANY AND THE CHRYSLER

CORPORATION/UNITED AUTO WORKERS, TO DEVELOP THE DETAILS OF HOW SUCH A PAYMENT METHODOLOGY WOULD BE CALCULATED AND IMPLEMENTED. WE ARE CURRENTLY IN THE PROCESS OF RESOLVING ISSUES RAISED BY THESE APPLICATIONS. WAIVERS LAUNCHING THESE PROJECTS WILL BE APPROVED ONLY WHEN WE HAVE ACCEPTED AN OPERATIONAL PROTOCOL WHICH DEFINES ALL ASPECTS OF THE PROJECT, INCLUDING QUALITY ASSURANCE AND FINANCIAL VIABILITY. WE ARE CONTINUING TO MEET WITH OTHER INTERESTED EMPLOYER AND UNION GROUPS. AS REQUESTED BY THE CONGRESS, WE WILL KEEP THE GAO FULLY INFORMED OF THE PROGRESS OF THESE PROJECTS.

OTHER RESEARCH IS LOOKING AT ALTERNATIVE GEOGRAPHIC AREAS ON WHICH TO BASE THE PAYMENT RATE, SUCH AS THE USE OF ZIP CODE AREAS, AS WELL AS METHODS TO UPDATE THE UNDERWRITING FACTORS THAT ARE CURRENTLY USED TO CALCULATE THE AAPCC.

CONCLUSION

PRIVATE HEALTH PLANS OFFER AN IMPORTANT ALTERNATIVE FOR BENEFICIARIES WHO SEEK A MORE FLEXIBLE HEALTH DELIVERY SYSTEM THAT CAN REDUCE OUT-OF-POCKET COSTS, OFFER INCREASED BENEFITS, AND HIGH QUALITY OF CARE. THESE PLANS PERMIT PHYSICIANS AND PROVIDERS TO CONTROL INDIVIDUAL MEDICAL TREATMENT REGIMENS WITHOUT THE BURDEN OF INCREASINGLY COMPLEX FEDERAL RULES.

OUR GOAL IS TO GIVE BENEFICIARIES AND HEALTH CARE PROVIDERS A FAIR CHOICE BETWEEN TRADITIONAL MEDICARE AND THE PRIVATE HEALTH PLAN OPTION. WE BELIEVE THE PHPO WILL ASSUME EVER-GREATER IMPORTANCE AS NEW PEOPLE "AGE INTO" MEDICARE THROUGH THE 1990S. ACTIVE WORKERS WHO HAVE BECOME ACCUSTOMED TO MANAGED CARE WILL PRESUMABLY WISH TO REMAIN IN THE SAME SYSTEM WHEN THEY BECOME ELIGIBLE FOR MEDICARE.

I WILL BE PLEASED TO ANSWER ANY QUESTIONS THAT YOU MAY HAVE.

Chairman **Stark**. Thank you, Bill. I am going to come back to the access thing, because as you know, I believe you. I've used poor mother as an anecdotal character for all these years that I've been concerned with Medicare.

But I did tell her the other day, I said, mom, get yourself over to Kaiser in Walnut Creek and sign up. It's a better deal for you than your medigap policies.

So she went over. I'm just looking for the letter, I had somebody bring it down from the office. They turned her down because she smokes. I think she also drinks, but she didn't tell them, and she's not telling me.

Now, I gather that's not fair under open enrollment, is it? Don't they sooner or later have to take her? Maybe Kaiser isn't qualified, or maybe she just hit the wrong time of the year.

She just wandered over to Kaiser and applied, and got this letter back saying our medical committee——

Dr. **Roper**. I sure would like to know the specifics.

Chairman **Stark**. Yes, I would too. What I see as a problem there, and I want to know if you share my feelings, is if you could run an HMO and have all the nonsmokers in the world, you would obviously stick us, the Government, with a higher cost down the road.

Dr. **Roper**. The adverse selection problem that you pose is one that researchers have struggled with for a long time. And the major safeguard that we have is the one that I'm talking with you about, and that is, we compel them to take all comers.

Chairman **Stark**. Was that not one of the problems that we, the Government, had in Florida, where an HMO was finding all kinds of subtle ways to screen out the less healthy folk—and I cannot remember; they're out of business now so it is unimportant—but creative accountants can probably find a way to detour dedicated physicians from taking every patient they might have taken before.

Dr. **Roper**. Sure. Well, the law and our regulations prohibit that kind of discriminatory practice in enrollment. But you're right. There have been anecdotes of things like putting the enrollment office on the fourth floor of a building without an elevator, so that you in effect don't take anybody who can't walk up four flights of stairs.

That's illegal, and we are eager to prohibit it.

Chairman **Stark**. I have another concern, not necessarily of the MIG's, but of a push toward HMO's in general. And I do not know if I have ever stated it directly to you, but I would like to now and ask you to comment on it.

I think that in the 20 years or more since Medicare has started, HCFA, the Inspector General, the GAO, PRO groups, and others, have developed an expertise in spotting overutilization of services.

I use bureaucrats in the very good sense of the word. We've got highly skilled bureaucrats both in the private intermediaries and in HCFA who can spot overutilization. Their whole career, if you get 20 years of Government service, I guess that's a career—has been focused toward holding down overutilization.

What I have said is that if you suddenly take a bureaucracy, and I don't care whether it is within Chrysler or within HCFA or within the telephone company or within Congress, and reverse their whole philosophy or mentality, and say, wait a minute, you are now no longer the regulator in charge of overutilizing; you must change your career—and at my stage in life, I do that very slowly and reluctantly—and suddenly make sure that we have enough utilization.

And I have said that this is something that's going to take time. We are going to have to take time, hopefully not 20 years, but we are going to have to develop the same skills at seeing that there isn't too effective a gatekeeper as we have developed in PRO's to prevent overutilization.

Is that a fair assessment of one of the major problems facing all of us in expanding capitation programs or other kinds of systems?

Dr. ROPER. I think it is a legitimate concern. And it is one that we and you have spoken to in the past.

I think, for example, that is what led the Congress to look a year and a half ago at the question of how physicians are paid in HMO's. I think further that's what led you to take action requiring that we have peer review of HMO services.

I guess what I'd say is, it is a legitimate concern. But we have a number of things in place to get at that problem.

I would like to take a minute to explain how the peer review organization or quality review organization and oversight of HMO services work. A number of tripwires are put in place to look for things happening to beneficiaries that are signals for the underprovision of services; for example, patients being admitted to hospitals for things that shouldn't happen—diabetes being out of control, hypertension being out of control, things of that sort.

And all of those cases are going to be picked out and reviewed carefully by physician reviewers.

In addition, there's going to be random screening of patients in the HMO to make sure that they are getting the services that they need.

While it is a legitimate concern, I think we have in place now a system for much more vigorous oversight, much tighter scrutiny of the capitated, private health plan part of Medicare than we do for the fee-for-service part of Medicare.

We know far more about the services given to beneficiaries in HMO's than we do about the whole rest of the program. And while we, I think, are rightly pursuing answers to your good questions, there's a whole other part of the system out there that we don't know much about.

Chairman STARK. Is there—and I am not suggesting this because I think we have gone out of control on liability for physicians and hospitals on all kinds of personal injury claims—but does a patient really have the same opportunity, and I don't mean in a legal sense, but in a practical sense, to recover from an HMO for malpractice as he or she would from a primary care physician who they would go after first?

Is there that threat which_also should constrain the HMO from withholding services?

Dr. ROPER. Some HMO's have attempted, in their private business, to have agreements with unruliest that had the unruliest waive their rights to lawsuits. That's not a part of the Medicare program.

You frown when I say that.

Chairman STARK. Well, that is sort of like my parking garage, that says your damage is limited to 15 cents if we smash your car.

Dr. ROPER. I think the idea of waiving a right to lawsuit and putting in place some alternative dispute resolution mechanism is a worthy idea that ought to be pursued.

Chairman STARK. Oh, I do too, but not by individual HMO's. I think no-fault or some other kind of concept might be good. But I'm not sure I want to let individuals do that.

Dr. ROPER. I know Kaiser in California has experimented with this. I do not know the latest.

Can I answer your question?

Chairman STARK. Yes, please.

Dr. ROPER. I am now informed about Mrs. Dorothy Stark of Walnut Creek, CA. The answer to why she was not admitted to Kaiser is that we don't have a Medicare risk contract in the area where she lives.

Kaiser does have private business serving her area, but we don't have a Medicare Kaiser plan in her area.

I would be glad to give you a fuller explanation.

Chairman STARK. No, just a list of where you have them would be fine, or a pamphlet on how to quit smoking in your golden years.

You have gone on at some length. What should we do about making sure there are HMO services available in every area?

Dr. ROPER. We ought to pay a fair amount, and do business in a reasonable way. And if this is an idea that is worthy, it will flourish.

Chairman STARK. OK. You go on at some length about the inability to apply uniform rules to, quote, medical circumstances across the health care system.

How are we going to protect beneficiaries from barriers to access or poor quality if we can't get some standards? We've got enough problems with standards of reimbursing hospitals, heavens knows. And I've often suspected that perhaps the major cost difference is part of this art of providing medical care not solely related to various cost indexes, but just to practices.

Don't we in risk contracting have to be even more specific than we do otherwise, in terms of Federal standards across the country?

Dr. ROPER. I don't know why you would have to be more specific or more detailed. I just think that this whole area needs an enormous amount of work.

This is an area that I have spent a lot of time on in the last few months myself. I think Medicare ought to be fostering research into the practice of medicine—and fostering means paying for it out of some Medicare trust fund dollars—to develop better knowledge about what works in the practice of medicine, so that information can be used to change the way doctors are paid.

Chairman STARK. You're a physician. How will the physician community react to that? By spending another $400,000 to defeat me? Or will they join in?

Dr. ROPER. I didn't contribute.

I think there is a growing realization among physicians that this is an idea whose time has come, and we doctors ought to be on the right side of this issue—that is developing this information.

I've met with Jim Sammons, the leadership of the AMA, and a number of other physician groups, and they are anxious to do this. There is some variation in just how to go about it. But I think this is an idea that everybody across the board, physician groups, payer groups, and you in the Congress, have an interest in fostering. I think what it is going to do is, No. 1, give better information to physicians so that they can do what is right for their patients. I cannot believe my colleagues want to practice without better information. Second, it will help us to design and manage the Medicare program better and Blue Cross plans, and whatever else to do their business.

It will help physicians, because they will be, to the extent they comport their practice to those standards, somewhat protected against liability lawsuits.

I just think this is——

Chairman STARK. How about if we cut a deal? I agree, and I do not think Members of Congress are at all qualified to get into that loop.

But it would be nice, when gathering all this information, to help the physician side of practicing, if we got a little more information out of the hospitals so that we could better administer the payment system.

And I would love to see you include our hospital reporting program in that, because I think it answers the whole question. If we have better information, we here will make better decisions based on the advice of professionals.

And I concur with that little amendment.

Dr. ROPER. Well, as you know, we are about to launch the demonstration of a reporting system in two States.

Chairman STARK. Can I just ask how that is going? Are the hospitals kicking and screaming? Or are you finding that it can be done?

Dr. ROPER. We've sent people to California and New York to investigate exactly how their systems are going. We have had further meetings back here in Washington and Baltimore, and the project is on course.

Chairman STARK. I think the GAO will testify—or they have noted—that we do not have data now on individual HMO members and how they use physician or out-patient services. And we have got very limited data on in-patient services.

How are we going to monitor utilization unless we either get that data, or is there another way we could do it without that data?

Dr. ROPER. I am not sure.

Chairman STARK. It is my understanding—and this comes from either prospective GAO testimony or something the staff has dug up—but HCFA has no data on what an individual HMO member does in usage of physician services, how many office visits, that sort of thing, or on outpatient services provided by an HMO.

And we have somewhat more limited data on in-patient services than we do from noncapitated programs.

Without that data base, how do we monitor whether there has been underutilization? Or are you going to get that data? I guess my question is—Don't we need that data?.

Dr. ROPER. We are now getting that data through the HMO quality review process that I explained briefly earlier. To just update you on that subject, we have now had 4,000 HMO hospitalization cases referred to the PRO's and quality review organizations.

They completed the review of about 250 of those cases, and of those cases, have found 6 quality problems that deserve further scrutiny. So the process is happening with respect to the hospitalization part of HMO's practice.

Chairman STARK. Let me just ask one final question. It has also been suggested that in the quality assurance program they are now required to review ambulatory care.

There has been some difficulty, I understand, in getting ambulatory care data. Could you say, kind of broadly and across the board, that it would be HCFA's intent that all data on medical care provided to the medical beneficiaries will be available to the quality organizations, confidential if necessary. But can we take down these barriers and have all the data assembled? Is that possible?

Dr. ROPER. Surely, that is our intention. The quality review of ambulatory services is something that is about to happen. It's just that this has never been done before, either in HMO settings or in fee-for-service settings. And it has taken awhile to figure out how to do it.

Chairman STARK. Thank you very much. Mr. Pickle?

Mr. PICKLE. Dr. Roper, help me to understand the plan or the discussion here this morning just for my own information.

Apparently the HMO's have had some difficulty in meeting their obligations. Some of them are going under, and some of them are leaving financial responsibilities. And we are looking at new ways to improve HMO's, I presume, and offer private plans.

How would a private health plan differ from the way the HMO operates now? What is the real difference between the two? And what is the choice we are facing here, or the administration is facing?

Dr. ROPER. Let me try to explain, sir. The concept, private health plan option for Medicare, is the broadest term. It includes HMO's. It includes also what the law, TEFRA, calls competitive medical plans. Those are usually called elsewhere, preferred provider organizations, PPO's.

And it also includes these demonstrations, Medicare insured groups, that we're about to begin.

Mr. PICKLE. Well, would a private health plan include, say, the MIG's?

Dr. ROPER. Yes, sir. It is an umbrella term to refer to all these things which are alternatives to the traditional Medicare program.

Now, in your question, you said some of the HMO's in the Medicare program have had problems. You're surely right. We think it is a small number, and we have taken aggressive action to deal with those problems, like the large HMO down in south Florida, IMC, that we kicked out of the Medicare program last year.

We are anxious to take care of our problems so that the program runs well.

Mr. PICKLE. Now, tell me, I'm trying to find out just what is the basic difference. We have the HMO's and nearly a million beneficiaries enrolled in them.

And while we've had trouble, you still want to assume that they will take the burden of relief in this medical field. But you're also recommending private health plans.

And I'm trying to find out how a private health plan will cut down on the costs, and how will that be more effective?

Dr. ROPER. Oh, I see your point. The idea inherent in each of these kinds of private health care plans is the concept of managed health care services.

And what that means is that somebody, a physician or other manager of the plan, is looking over the whole course of a patient's illness, and making decisions about what services ought to be given out of the hospital, or in the hospital, or after the hospitalization, managing that care in a way that does best for the patient but is an efficient delivery of services.

That is to be contrasted with the usual way the Medicare program works, in which patients are essentially on their own to go for doctor services, maybe to many doctors; to a hospital here, to a nursing home there, for home health services somewhere else. That's the difference.

I believe that this managed care framework under the private health plans offers better, more continuous care with complete oversight, and offers the opportunity for better, cost-effective care.

Mr. PICKLE. Is the rate of reimbursement to each group the same?

Dr. ROPER. The amount we pay these plans depends on where they are in the country. The payment amount, the so-called AAPCC, differs according to the county where the plan is located.

The HMO's and competitive medical plans are paid on the same basis. The MIG's idea has some additional flourishes that you wrote into the law last December.

Mr. PICKLE. If we had a private health plan in operation, is the responsibility of the Government heavier for a private plan than it is for an HMO? Is the Government apt to be cutting out benefits to the poor, as against the rich?

Is it a heavier responsibility of the Government if you went to the private health plan than under the other?

Dr. ROPER. Well, remember again, HMO's are private plans. They're a part of this overall idea of private health plans.

And typically, HMO's and other private plans offer services beyond what Medicare usually does, at lower out-of-pocket costs.

So especially poor Medicare beneficiaries stand to gain the most from enrollment in HMO's or other private plans.

Mr. PICKLE. Well, in effect, I take it then that you are recommending that we not only try to improve the HMO's, make them more efficient, but that we also ought to put emphasis on the private health plan approach and have both or a combination of them?

Dr. ROPER. Yes, sir. I think it's one of the most fruitful prospects for the future.

But let me make the point that I made a couple of times earlier: we are not trying to force or compel or herd beneficiaries into private plans against their will. We are willing to trust their judgment. If they don't want to enroll, that's fine.

They are best able to judge whether they want to stay in traditional Medicare or not.

Mr. **Pickle**. All right, I thank you.

Thank you Mr. Chairman.

Chairman **Stark**. Mr. Chandler.

Mr. **Chandler**. Thank you, Mr. Chairman.

I could not help but think when the chairman talked about his mother being declined by Kaiser, that it might be a little like President Eisenhower playing golf out in the Rose Garden when he was President. And a squirrel ran across the path of the ball. And he said, get that damn thing out of here. And the next day the Park Service was out trapping all the squirrels.

And I have a feeling that every man, woman, and child in the bay area named Stark is getting a personal visit from somebody named Kaiser to enroll them today.

Dr. **Roper**. You understand how HCFA works, sir.

Mr. **Chandler**. In your written testimony you cite on page 10 that a significant portion, in this case, Group Health of Puget Sound, a significant portion of that HMO's savings came from reducing discretionary surgery.

And obviously, that is what we are up to here. The chairman's and Mr. Pickle's questions concern that struggle we have between one incentive creating an emphasis on providing too much service, and perhaps in this case, the other incentive moving in the opposite direction, increasing concern that we would be providing too little.

And the thing I wondered also, in your testimony you mentioned your father and your confidence that he was a better decisionmaker than someone else, and I agree.

And after some experience now with the peer review organization, I wonder how effective it is, if you could comment on who does it. How much credence do we have a right to place in it?

And also back to that comment about your father. How much does patient review, organization or effort cost? Because again, I think I'd almost be more interested in what the patients thought of the care they were getting than peers of the providers. Could you comment on that?

Dr. **Roper**. You've raised a number of important issues. Let me try and deal with each of them.

First, your point about medical uncertainty and the need for better knowledge about what works in the practice of medicine is clearly the case.

I heard, in fact, on the radio this morning that today's New England Journal of Medicine apparently has an article—I have not seen it—on women who had cancer, and those who did have surgery and those who did not, and the relationship between whether or not you had surgery to whether or not you had health insurance.

And one of the commentors that I heard on the radio this morning said, it is not at all clear that the women should have had surgery. And maybe it was the women who had insurance and had surgery that were harmed by the process; not the way we would ordinarily look at that.

So that is an area that needs much, much work.

As far as how the peer review organizations work, I think they work well, but they need to work better. Secretary Bowen and I have spent the last 2 years, personally and institutionally, putting a lot of effort into improving the work the peer review organizations do.

I think it is vitally important that doctors who practice medicine in Medicare feel like they are fairly judged by their peers, other doctors, in the medical judgments that they make.

You ask who renders those judgments? At a screening level, it is often a nurse who does the screening. But the determination of whether or not something is proper or appropriate is done by a physician, a true peer of the person who rendered the care.

Should there be more patient input in those kinds of questions? Yes, and in fact, that's why each of the peer review organizations now must have a consumer, a Medicare beneficiary, on the board of that peer review organization to make sure that their thoughts and feelings are incorporated into the work of the peer review organizations.

I spend a good deal of my time these days meeting with, talking with, AARP and other groups representing the elderly. And I think we have not listened enough to their concerns about specific medical questions.

I have come to believe that there is an awful lot of good sense in people who want to be given freer rein in judgments about their own medical circumstances. And we doctors, and we, the Medicare program, ought to pay more attention to that.

Mr. **Chandler**. In the case of the HMO's, because I am familiar with Group Health at home, their members are very active—well, they run the organization, they hire the management, that's the way the thing works.

And I don't know just how much regulation there is of the non-Medicare side of the business. But my guess is, not much. And yet, people are clearly satisfied with the service they're getting, because they go back; they continue to utilize it.

And I almost wonder if this type of provision of service for the elderly requires less in the way of regulation and review than does the traditional method of fee for service, because of this membership involvement, and the opportunity, if you will, to throw the rascals out if they're not satisfied with the service?

And maybe we ought to recognize that, and back away a little bit and let them run their own deal.

Dr. **Roper**. Your point is well made. And I have argued that point for a good long while. I came to the conclusion a year and a half or so ago that we had to have tighter scrutiny in this area for political as well as many other reasons.

You were not going to be willing to let us pursue this agenda without being able to give you assurances that this was an area that we were paying attention to. That is just a fact of life.

Mr. **Chandler**. Well, you do not have to do it for my political reasons.

Mr. Chairman, I yield back.

Chairman **Stark**. Mr. Coyne.

Mr. **Coyne**. Thank you, Mr. Chairman.

Dr. Roper, I wonder if you would comment and elaborate on why in your judgment 29 HMO's ceased to continue their Medicare risk contracts last year?

Dr. **Roper**. The reason is, they made business decisions that it was not in their interest to continue in the Medicare program.

Most of those plans had almost no Medicare enrollees. Some of them had earlier sign-up agreements that they had really never pursued.

The total enrollment of those 29 plans was about 80,000 or 90,000 beneficiaries, out of a million who were enrolled in all Medicare HMO's. Of the beneficiaries that were enrolled by those plans that dropped out, most of them joined other Medicare HMO's in their area, because many parts of the country are served by multiple plans.

In essence, my point is that the fact that some plans dropped out is a part of the business. One of the concerns that is often voiced, let me be quick to point out, is that we do not have a fully satisfactory mechanism for calculating how much to pay Medicare private health plans.

And I touched on that in my testimony. But we are aggressively pursuing a number of avenues that we hope will lead to a better payment mechanism.

But even once we are fully satisfied there, we are going to have a continual coming and going of plans in this business, just like we do in all other parts of our economy.

Let me just add one point. We have to make sure Medicare beneficiaries are not harmed by that process. And we have a number of safeguards that I'd be happy to elaborate on. Thank you.

Mr. **Coyne**. Are Medicare insurance groups required to return any of their cost savings back to the beneficiaries in the form of supplemental Medicare benefits, as are HMO's? Or can the company reap the cost savings and the profits from their activities?

Dr. **Roper**. OBRA 1987 spoke to that point directly, and said that the group, the Medicare insured group can keep 5 percent of the profits. And the amount above that, if there is an overage, has to either be returned to the Medicare program, or passed back to the beneficiaries with enhanced benefits or reduced copayments.

Mr. **Coyne**. Thank you.

Chairman **Stark**. Mr. Daub?

Mr. **Daub**. Thank you, Mr. Chairman. Dr. Roper, it is always good to see you.

Dr. **Roper**. How do you do?

Mr. **Daub**. Did you think I might not make it today?

Dr. **Roper**. No, glad to see you.

Mr. **Daub**. Nice to see you. Are we saving money on these contracts, these million people that are in these programs? Are we saving money on them?

Dr. **Roper**. I don't know. And in fact, that is not our intention. This is a mechanism that over time, I think, will save money systemwide in the health care system and in the Medicare program.

But the immediate concern is offering a better system of health care for Medicare's beneficiaries who choose to enroll.

To the extent we pay 95 percent of what our actuaries calculate we would have been spending, yes, we are saving that 5 percent. But I must confess, there is some imprecision in those calculations.

So I can't tell you to the dollar how much we're saving.

Mr. DAUB. With your emphasis on peer review, do you think that the process you now have currently in place is working?

Dr. ROPER. Peer review generally, or of these plans?

Mr. DAUB. Well, generally. You've indicated you are trying to emphasize improvements in the process itself.

Dr. ROPER. It is working, but it needs to be better. I am saying I am not satisfied with it.

Mr. DAUB. How likely is it that non-peer-review organization groups will be used for such evaluation in the future?

Dr. ROPER. Of HMO's?

Mr. DAUB. Yes.

Dr. ROPER. Well, we have gone through a process the last few months of putting out a competitive bid for the contracts in 24 States, and in 2 or 3 States we have selected non-PRO organizations.

In most of the country, we are using the existing PRO's to do the review of HMO's. But we do have a couple or three States where nontraditional organizations, which we call quality review organizations, are undertaking this review.

Mr. DAUB. A number of Medicare HMO's got out of the business in rural counties because the HMO's felt payments were too low.

What is your view of this? And should we adjust payments to keep HMO's available to rural Americans?

Dr. ROPER. Well, I indicated to Mr. Coyne my general response about the coming and going of contracting plans. As far as rural HMO's, to the extent the Congress and we have increased how much relatively we pay rural hospitals with respect to urban hospitals, that will be incorporated into the amount we pay through the AAPCC to these plans.

And so the amount we pay to rural HMO's will be increasing. And they will be, I presume, more willing to undertake this business in rural areas.

Mr. DAUB. So administratively, you are going to translate the wage index formulas and some of the other things we've been doing to affect the reimbursement schedules as well?

Dr. ROPER. Yes, the AAPCC is simply a mechanism for calculating what would have been spent in traditional Medicare. So all those changes are factored in.

Mr. DAUB. I am very glad to hear that. And I would ask two rather quick things. I would like someone on your staff to contact a Dr. Judith Butler, you can get the information from my office, who runs a clinic practice in Superior, Nebraska.

She is having a great deal of difficulty in terms of the constraints we have placed on changes in bundling and on tests, reducing payments for those services substantially. It doesn't make sense.

And if that is happening, then that is why all across rural America a number of the clinics are being closed. They just simply are not getting impacted fairly when the percentages of reductions are applied across the board.

I would like you to look into it.

Dr. ROPER. We would be glad to.

Mr. DAUB. And may I just ask you for a yes or no answer, are we very near to resolving the issues of the Blue Cross/Blue Shield problems in Iowa and Nebraska?

Dr. ROPER. Sure hope so. The Secretary is thinking, and I hope we will get a reading in the next few days.

Mr. DAUB. As you know, I am very concerned that we not only resolve the situation promptly, but that we can then put the pressure on the current contractor and terminate it. And I support that termination at this point in time, unless there is a division of the contracts between Iowa and Nebraska, to maintain with quality, prompt, efficient reimbursement under part B.

Dr. ROPER. I hear you. We do too.

Mr. DAUB. Thank you.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Thank you, Dr. Roper. I don't have any questions for you at this time. I am sure we will be revisiting this issue along down the line.

I appreciate your coming. Thanks very much.

Dr. ROPER. Thank you, sir.

Chairman STARK. Our next witness is Michael Zimmerman, Senior Associate Director, Human Resources Division, the General Accounting Office.

Mr. Zimmerman, welcome, and please proceed.

STATEMENT OF MICHAEL ZIMMERMAN, SENIOR ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY EDWIN P. STROPKO, GROUP DIRECTOR

Mr. ZIMMERMAN. Thank you, Mr. Chairman.

Let me begin by introducing Mr. Ed Stropko, who is here with me today. Mr. Stropko is in charge of our prepaid health work, and has been involved in a number of the studies that I am going to be discussing with you today.

We are pleased to be here to discuss our work on HCFA's management of the Medicare-HMO program.

Specifically, you asked us to address the following topics: the adequacy and reasonableness of the method for paying HMO's with Medicare risk contracts; the adequacy of HCFA's oversight of HMO's to assure quality of care and general Medicare compliance; and the issues that should be resolved before Medicare implements a nationwide initiative to contract on a prepaid basis with employer-sponsored retirement health plans, referred to as Medicare insurance groups, or MIG's.

Let me summarize our views on each topic, starting with the payments issues.

Available research shows that the AAPCC is a poor predictor of what enrollees would cost Medicare under the fee-for-service system.

The adjustments used by the AAPCC explain less than one percent of the variance in per beneficiary Medicare cost, and research indicates that at most, better adjustors will account for 20 percent of this variance.

Also research shows that a primary premise of using the AAPCC to set HMO rates, that HMO's enroll a cross-section of Medicare beneficiaries, is not currently valid.

The body of evidence is that HMO's enroll beneficiaries who are healthier on the average than fee-for-service beneficiaries. This favorable selection in turn means that the AAPCC method overcompensates HMO's for the beneficiaries actually enrolled.

The ACR process is supposed to ensure that to the extent the AAPCC method results in overcompensation, the Medicare program or its beneficiaries gain rather than the HMO.

This is supposed to result from limiting HMO profits to the rate of return on their non-Medicare enrollees, and plowing back any excess as additional benefits, or returning the excess to Medicare.

Our ongoing work indicates that HCFA has not effectively used the ACR process to accomplish this objective.

Specifically, to process a subject to HMO manipulation and error, because HCFA has not enforced its requirements that an HMO use its historic cost data and utilization data as a basis for forecasting its ACR, and follow the prescribed methods of computing the ACR.

Our work is still underway, and we expect to have a report this spring that will recommend ways HCFA can improve its oversight of the ACR process.

We also expect to issue our report this spring on HCFA's oversight of the HMO program. Our work is showing three areas of concern.

HCFA has very limited data with which to centrally monitor HMO's quality of care, although this situation is improving.

Second, HCFA's staffing for monitoring has increased, but less so than the growth of HMO's.

And third, HCFA's process for assuring HMO's compliance with Federal requirements have not been very effective in dealing with HMO's that are either unwilling or unable to meet the requirements.

Let me discuss just two of these, the one dealing with the adequacy of data, and the other, the compliance issue.

Because the contractor HMO's and not Medicare pay providers, HCFA has no data on individual HMO members use of physician or outpatient services, and only limited and sometimes incomplete data on in-patient services.

The absence of such data means that HCFA cannot screen its files as it can in the regular Medicare program to identify providers having aberrant utilization or charge patterns.

The data HCFA does receive is that needed to monitor HMO's compliance with Federal financial solvency, balance sheet and income data, and to calculate HMO payments, primary enrollment data.

While the data HCFA obtains from HMO's is too limited to do the types of provider analysis possible with its data bases on fee-for-service claim payment, HCFA could make better use of HMO data for program monitoring.

Calculating, for example, HMO disenrollment data is one area with potential for doing so.

Chairman STARK. Mike, you skipped over saying that HMO's spent all their time on financial compliance. It seems to me where we got beat by these couple of operations in Florida and California that guys were just taking the money and going south, or else charging us for the kinds of activities that were only permitted in Mr. Swaggart's church.

And I just wondered whether or not you are going to go on to that? Or are you just saying that they do a fine job in the financial monitoring? Or aren't you going to talk about that?

Mr. ZIMMERMAN. Well, I would not say they do a fine job in financial monitoring. What I was saying, some of the data that is reported to them is of the financial type, and the data that isn't reported to them, that they need to make quality decisions dealing with utilization, in-patient visits, and so on, is totally lacking, or totally unavailable to them.

So if they're ever going to be able to get on top of the quality question and the issue that you raised earlier with Dr. Roper, they're going to need that kind of information. Patient encounters, types of services that were provided; that type of information would be needed for them.

Chairman STARK. OK. But it is my understanding that there are no financial reserve requirements or capital adequacy requirements. And in one instance, I think we got a cash flow of something like $30 million a month. So all some guy has to do is go 90 days without paying his bills and he's put $100 million in his pocket, and off he goes to Panama or some other friendly nation.

And that is basically pretty close to what happened. Are you going to comment on that?

Mr. ZIMMERMAN. Well, I can ask Mr. Stropko to speak to what went on.

Chairman STARK. All right.

Mr. ZIMMERMAN. All right, let me ask him to respond to the cash flow and financial reporting that he's aware of with regard to IMC. I gather that's what you're talking about.

Chairman STARK. Well, that is where it showed up as the potential source.

Mr. STROPKO. Suffice it to say that the best data HCFA has with regard to HMO monitoring is the financial data, as good as it is.

For organizations like IMC that are particularly troubled, HCFA does get quarterly financial reports from the HMO. So they are a little bit behind in terms of identifying major problems, though HCFA does get the data.

As far as the requirements that must be met, they're fairly liberal. HMO's have to have a positive net worth, and they have to show profitability over a period of time—those types of general requirements. The requirements are, however, generally less stringent than those for other types of insurers.

Chairman STARK. Well, it is my understanding that States may impose certain reserve requirements, and that Title 13 of the Public Health Service Act imposes reserve requirements for federally qualified plans.

My question is, does HCFA look into or did you look into the adequacy of those reserves, and/or the adequacy of somebody monitoring them?

For instance, banks get surprise examinations, and if the money isn't there, you close the bank and put the banker in jail.

In some of these plans, you are going to be talking about big bucks, and a real opportunity for financial chicanery. And I just wonder, it is a little bit outside of our jurisdiction here in the Health Subcommittee, but if they go broke, you get a lot of beneficiaries who are in trouble.

And I just wonder if you can comment.

Mr. **Zimmerman**. The HMO's are supposed to be submitting information periodically. Of course, as I point out in my statement, sometimes they do and sometimes they don't.

Chairman **Stark**. Then what?

Mr. **Zimmerman**. Then hopefully, HCFA, if it has a staff available to it, and there is some question as to whether they have the necessary staff level to pursue the HMO's that are in that position, they have to notify them and start discussing with them their financial state, and whether they are going to be able to support the program.

Obviously, this takes a long period of time, and there is a risk that over time the HMO's become insolvent, collapse, and we have a situation, though hopefully not on as big a scale, as we had in Florida.

I guess the premise here that these organizations are in business to do business, and that they will deal up front and fair with the Government as to what their intentions are; and for the most part they have.

There are some, however, that have participated in the program that have not dealt fairly with the Government. And I guess the Government is just not in a position to know that as quickly as it needs to know to protect the program and the beneficiaries.

Mr. **Stropko**. Mr. Chairman, we haven't looked at the adequacy of the Public Health Service's standards. We have looked at some of the problems in overseeing and monitoring those standards and getting HMO's to comply, however.

Obviously, HMO's that are going out of business have an interest in turning things around and bringing themselves up to speed. But what we have found when we looked at HCFA's process for dealing with HMO's that are going out of business, is that HCFA really does not have authority to do much except observe the problem as it is unfolding.

And that calls into question whether or not HCFA should have greater authority perhaps, for example, to stop the HMO from enrolling more Medicare beneficiaries until their financial status improves. We've seen cases where, before insolvency occurred, there were many years of financial trouble during which the HMO's kept enrolling Medicare beneficiaries. And that, in my judgment, is not appropriate.

Chairman **Stark**. There was an awful lot of smoke there before we really found the fire.

Mr. **Stropko**. You bet. And IMC is not the only example of that occurring. It is occurring today in other places.

Chairman **Stark**. It is occurring today in other places?

Mr. **Stropko**. Yes.

Mr. **Zimmerman**. This touches on the next issue I was going to discuss, and that is the question of compliance.

During the early phases of the HMO program, HCFA could do little with a noncompliant HMO short of terminating its contract.

Legislation in 1986 and more recently in December 1987, broadened HCFA's sanction authority by allowing it to suspend new Medicare enrollments for such practices as submitting inaccurate data.

But I might tell you that they cannot suspend them if they don't submit any data at all, something which we will discuss in our report.

But this sanction cannot be applied to all the problems identified in the cases we reviewed. And among noncompliance problems for which HCFA still cannot suspend enrollment are those involving fiscal soundness and certain marketing and enrollment practices, the issues that we are discussing with you now.

Given the diverse nature of compliance problems we identified, we believe it may be necessary for the Congress to consider giving HCFA broader discretion to use its sanction authority, particularly with regard to Medicare enrollments.

We think such authority could be useful for dealing with HMO's that for whatever reason fail to make substantial lasting progress toward meeting a Medicare requirement.

Let me turn now to the issue of MIG's. Our call for caution in this program stems from two factors. First in the past HHS has experienced problems with new initiatives that exhibit rapid growth, which the MIG program has the potential to do.

And second, capitation of organizations that are neither health care providers nor commercial insurers is an untested concept requiring development of new reimbursement methods and beneficiary and program safeguards.

The methods HCFA is considering for reimbursing MIG's vary significantly from those it uses to reimburse risk HMO's, and I might say, we know there are some problems already with the risk HMO methods.

There should be reasonable assurance that the payment rates under this new program do not exceed what Medicare otherwise would pay if this group of beneficiaries remained in the fee-for-service sector.

HCFA plans to develop a payment method based on Medicare's fee-for-service experience, with MIG beneficiaries. While it is possible to set an initial rate on this basis by using Medicare claims files, updating the rates in subsequent years can become a problem.

This is because once an employer-based plan enters the program, HCFA will no longer process its Medicare retiree claims, and will therefore not have any fee-for-service data with which to compare the rates.

As time passes, it will become increasingly difficult to measure objectively whether under or overcompensation to MIG's is occurring.

Also HCFA's current ACR method would not apply to MIG's, because the ACR is based on provider's commercial rates, and MIG's, being neither commercial insurers nor providers, do not have commercial rates.

Including an ACR-like component in the MIG rate-setting method is particularly important, because it is through this means that HCFA can assure that beneficiaries receive a reasonable level of health care coverage for the payments made.

As with any mechanism for delivering prepaid health care, the MIG program needs safeguards to help assure that risk bearing organizations have the administrative systems, financial capacity, and minimum enrollment necessary to assume risks and provide quality care.

Existing key legislative safeguards for HMO's may not be effective for MIG's. This is because the safeguards are based on the presumption that the organization seeking a Medicare contract is in fact a health care provider already established in the business of providing capitated health services to commercial clients, presumptions which we believe are not valid for most employer-based plans.

Additionally, existing statutory safeguards apply only to the organization contracting with HCFA, not its subcontractor. To the extent that the MIG's elect to provide services through risk-bearing subcontractors, a situation that we all became familiar with involving IMC, a situation can arise where such subcontractors function as HMO's without having to meet financial and quality of care requirements.

Given the uncertainties about payment methods and the applicability of existing safeguards for the program and its beneficiaries, we believe the best approach to the MIG program is the one provided by the Congress in the 1987 reconciliation act. That is, proceeding with caution by authorizing HCFA to fund a limited number of demonstration projects.

HCFA plans to enter its first MIG contract this summer with the Amalgamated Life Insurance Co., and it is authorized to contract with two others.

As you know we have been asked to monitor MIG contracts as they are awarded and report on how well they're doing, and we are in the process of doing that.

Let me just conclude my statement here, Mr. Chairman. We would be glad to answer any further questions.

[The statement of Mr. Zimmerman follows:]

STATEMENT OF MICHAEL ZIMMERMAN
SENIOR ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION
U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss our work on the Health Care Financing Administration's (HCFA) management of the Medicare HMO program. Specifically, you asked us to address the following topics: (1) the adequacy and reasonableness of the method for paying HMOs with Medicare risk contracts; (2) the adequacy of HCFA's oversight of HMOs to assure quality of care and general Medicare compliance; and (3) the issues that should be resolved before Medicare implements a nationwide initiative to contract on a prepaid basis with employer-sponsored retiree health plans, referred to as Medicare Insurance Groups (MIGs).

Medicare's current risk-based HMO program has been operational since April 1985. Since then, the numbers of both HMOs with Medicare contracts and beneficiaries enrolled have grown dramatically. Managing the growth of this initiative and maintaining oversight has been a challenge for HCFA and not without problems.

Let me summarize our position on each topic.

There are some widely acknowledged limitations in the current Adjusted Average Per Capita Cost (or AAPCC) method of paying HMOs. Available research shows that HMOs tend to enroll healthier than average persons and to the degree this occurs, overcompensation results. The Adjusted Community Rate (or ACR) process is a statutory safeguard intended to help assure that if the AAPCC rates overcompensate HMOs, the Medicare program and/or its beneficiaries gain either through reductions in the rates or the provision of additional services to beneficiaries. But, our ongoing review of the ACR process is showing HCFA's oversight and enforcement of ACR requirements are not sufficient to assure this is occurring.

HCFA has tightened up its oversight of the HMO program considerably since May 1987, when International Medical Centers (IMC), a south Florida HMO, was found by the State to be insolvent and placed in receivership. Our ongoing review of HCFA's oversight, however, is showing that in many cases where HMOs are unable or unwilling to resolve compliance problems in a timely fashion, HCFA's only alternatives are to terminate the contract or tolerate continued noncompliance. This suggests it may be necessary for the Congress to provide HCFA broader discretion in using its sanction authorities.

In our recent report on HHS's MIG proposal,[1] we point out that HCFA needs to develop a new payment method and new beneficiary safeguards, as those pertaining to HMOs often cannot be applied. HCFA should demonstrate that it has adequately tested such new features before decisions are made to implement this program nationwide.

Let me now discuss these topics in more depth.

AAPCC DOES NOT ADEQUATELY ADJUST FOR ENROLLEE HEALTH STATUS

Available research shows that the AAPCC is a poor predictor of what enrollees would cost Medicare under the fee-for-service system. The adjusters used by the AAPCC computation process explain less than 1 percent of the variance in per beneficiary Medicare costs and, moreover, research indicates that at most, better adjusters will account for 20 percent of this variance. Furthermore, available research shows that a primary premise of using the AAPCC to set HMO rates, that HMOs enroll a cross section of Medicare beneficiaries, is not currently valid. The body of evidence is that HMOs enroll beneficiaries who are healthier on average than fee-for-service beneficiaries. This "favorable selection" in turn means that the AAPCC method overcompensates HMOs for the beneficiaries actually enrolled.

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[1] Medicare: Uncertainties Surround Proposal to Expand Prepaid Health Plan Contracting (GAO/HRD-88-14, Nov. 2, 1987).

The ACR process is supposed to assure that, to the extent that the AAPCC method results in overcompensation, the Medicare program and/or its beneficiaries gain rather than the HMO. This is supposed to result from limiting HMO profits to the rate of return on their non-Medicare enrollees and plowing back any excess as additional benefits or returning the excess to Medicare. Our ongoing work indicates that HCFA has not effectively used the ACR process to accomplish this objective.

Specifically, the process is subject to HMO manipulation and error because HCFA has not enforced its requirements that an HMO (1) use its historic cost and utilization data as a basis for forecasting its ACR; and, (2) follow the prescribed methods of computing the ACR.

Our work is still under way, and we expect to have a report this spring that will recommend ways HCFA can improve its oversight of the ACR process.

HCFA OVERSIGHT OF THE HMO PROGRAM

We also expect to issue our report this spring on HCFA's oversight of the HMO program. Our work is showing that (1) HCFA has very limited data with which to centrally monitor HMOs' quality of care, although the situation is improving; (2) HCFA's staffing for monitoring has increased, though less so than the growth of HMOs; and (3) HCFA's processes for assuring HMOs' compliance with federal requirements have not been very effective in dealing with HMOs that are either unwilling or unable to meet requirements.

Adequacy of Data

Because the contractor HMOs, and not Medicare, pay providers, HCFA has no data on individual HMO members' use of physician or outpatient services and only limited (and incomplete) data on inpatient services. The absence of such data means that HCFA cannot screen its files, as it can in the regular Medicare program, to identify providers having aberrant utilization or charge patterns. The data HCFA does receive is that needed to monitor HMOs' compliance with federal financial solvency requirements (e.g., balance sheet and income data) and to calculate HMO payments (primarily enrollment data).

While the data HCFA obtains from HMOs is too limited to do the types of provider analysis possible with its data bases on fee-for-service claims payments, HCFA could make better use of the HMO data for program monitoring. Calculating HMO disenrollment rates, for example, is one area with potential for doing so.

High disenrollment rates can indicate potential problems in several areas such as misleading advertising and beneficiaries' problems in gaining access to care. HCFA does not produce disenrollment statistics for monitoring HMOs, although they can be produced from HCFA's databases. Using these databases, we found that about one out of six people, or 16 percent, enrolling in 95 risk-based HMOs (between July 1985 and June 1986) terminated their enrollment within 1 year of enrolling. The variation in disenrollment rates was substantial, ranging from an average of about 3.5 percent for the 10 HMOs having the lowest rates, to about 36 percent for the 10 having the highest rates. It is important that HCFA look at HMOs with relatively high disenrollment rates, as we have observed that HMOs having compliance problems also often had high disenrollments in relation to other HMOs.

In mid-1987, HCFA initiated two programs that should increase its ability to monitor HMO quality. These programs are an HMO peer review program, and a system for tracking beneficiary and provider complaints against HMOs. Prior to these efforts, HCFA did not look systematically at the care being provided to HMO members nor effectively use complaints to identify potential problems. It is too early to assess the effectiveness of either effort. Some problems, however, are being encountered by peer review organizations in obtaining enough data to draw a statistically valid sample of cases to review. Aware of this start-up problem, HCFA has formed a study group composed of its operating components to determine how best to correct it.

HCFA Staffing Lags HMO Growth

Although the number of risk-based HMOs and Medicare enrollees increased substantially since 1985, HCFA's staff for monitoring them, while increasing, has not kept pace. Also, HCFA officials have expressed concern over the need to focus staff on resolving problems of a few HMOs such as IMC, instead of routinely monitoring all HMOs to help forestall problems. This reactive tendency can be seen in HCFA's central office site visits to HMOs during the program's first 27 months, when over half of all visits to HMOs were to IMC.

To remedy this situation, HCFA began implementing new monitoring procedures in July 1987 that require each HMO to be reviewed at least every 2 years. HCFA expects this will help it identify and resolve problems early. Whether this is so will depend on the extent and nature of problems disclosed by the new monitoring system and the two additional data gathering and review efforts just discussed. In any event, HCFA believes additional staff will be needed to monitor HMO activities.

Compliance Process Limited--Broader Authorities Needed

When HMOs are willing and able to correct identified compliance problems, resolution is generally timely. A few HMOs, however, have had recurring compliance problems or were either unresponsive or untimely in responding to HCFA's requests for corrective action. Three HMOs we selected as case studies provided examples of compliance problems involving financial solvency, marketing practices, and--in the IMC case--various issues related to financing, quality of care, and management.

It can take a number of years for an HMO's compliance problems to become resolved, our case studies show, and over this period the HMO is often free to continue enrolling beneficiaries. Ironically, an increasing Medicare enrollment in an HMO can itself become a reason for HCFA not to terminate a contract where problems persist. For example, in the face of continuous compliance problems but fearing adverse effects of termination, HCFA permitted IMC to grow from about 5,000 Medicare enrollees in 1981 to over 135,000 before capping Medicare enrollment in 1986.

In each of the cases studied, HCFA chose instead of termination to continue working with the HMO. This is the preferred course of action when there is prompt and significant progress toward compliance--but not, in our opinion, when such progress is absent.

During the early phases of the HMO program, HCFA could do little with a noncompliant HMO short of terminating its contract. Legislation in 1986 and most recently in December 1987 broadened HCFA's sanction authority by allowing it to suspend new Medicare enrollments for such practices as submitting inaccurate data to

HCFA. But this sanction cannot be applied to all the problems identified in the cases we reviewed. Among noncompliance problems for which HCFA still cannot suspend enrollment are those involving fiscal soundness, and certain marketing and enrollment practices.

Given the diverse nature of compliance problems we identified, it may be necessary for the Congress to consider giving HCFA broader discretion to use the sanction of suspending Medicare enrollments. Such authority could be useful in dealing with HMOs that--for whatever reason--fail to make substantial, lasting progress toward meeting a Medicare requirement.

UNCERTAINTIES SURROUND MIG PROPOSAL

In our report on the MIG proposal we proposed that the Subcommittee not give blanket authority to contract with MIGs until HCFA can demonstrate that the MIG rate-setting methods and beneficiary and program safeguards are reasonable and adequate.

Our call for caution in this program stems from two factors: (1) in the past, HHS has experienced problems with new initiatives that exhibited rapid growth, which the MIG program has the potential to do; and (2) capitation of organizations that are neither providers of services nor commercial insurers is an untested concept requiring development of new reimbursement methods and beneficiary and program safeguards.

Need to Demonstrate Reimbursement Methods

The methods HCFA is considering for reimbursing MIGs vary significantly from those it uses to reimburse risk-based HMOs. There should be reasonable assurance that the payment rates under this new method do not exceed what Medicare otherwise would pay if this group of beneficiaries remained in the fee-for-service sector.

HCFA's AAPCC methodology cannot be directly used for employer-based plans because Medicare retirees enrolled in such plans may have different health care costs than Medicare beneficiaries in general. Consequently, HCFA plans to develop a payment method based on Medicare's fee-for-service experience for the plans' retiree beneficiaries. While it is possible to set initial rates on this basis by using Medicare claims files, updating the rates in subsequent years can become a problem. This is because once an employer-based plan enters the program, HCFA will no longer process its Medicare retirees' claims and will therefore not have fee-for-service data with which to compare the rates. As time passes, therefore, it will become increasingly difficult to measure objectively whether under- or over-compensation to MIGs is occurring.

Also, HCFA's ACR method would not apply to MIGs because the ACR is based on a provider's commercial rates and MIGs, being neither commercial insurers nor providers, do not have commercial rates. Including an ACR-like component in the MIG rate-setting method is particularly important because it is through this means that HCFA can assure that beneficiaries receive a reasonable level of health care coverage for the payments made.

Need to Demonstrate Effectiveness of Safeguards

As with any mechanism for delivering prepaid health care, the MIG program needs safeguards to help ensure that the risk-bearing organizations have the administrative systems, financial capacity, and minimum enrollment necessary to assume risks and provide quality care. Existing key legislative safeguards for HMOs may not be effective for MIGs. This is because the safeguards are based on the presumption that the organization seeking a Medicare contract is a health care provider already established in the business of providing capitated health care services to commercial clients--presumptions not valid for most employer-based plans.

Additionally, existing statutory safeguards apply only to the organization contracting with HCFA--not its subcontractor. In our July 1986 report on the HMO demonstrations,[2] we found that the effectiveness of existing safeguards can be limited in those HMOs, such as IMC, which pass on much of the risk of enrollee health care costs to subcontractors. To the extent that MIGs elect to provide services through risk-bearing subcontractors, a situation can arise where such subcontractors function as HMOs without having to meet any of the federal and state financial and quality-of-care requirements normally imposed on these entities.

Given the uncertainties about payment methods and the applicability of existing safeguards for the program and its beneficiaries, we believe the best approach to the MIG program is the one provided by the Congress in the 1987 Omnibus Budget Reconciliation Act. That is, proceeding with caution by authorizing HCFA to fund a limited number of demonstration projects. HCFA plans to enter its first MIG contract this summer with the Amalgamated Life Insurance Company and is authorized to contract with up to two additional groups.

This concludes my prepared testimony. I would be happy to answer any questions you may have.

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[2] Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations, (GAO/HRD-86-97, July 16, 1986).

Chairman **Stark**. In our authorization of the MIG Demonstration Project, GAO was asked to monitor the development of the demonstration.

Are you getting all the cooperation you need to implement this oversight requirement on your agency's part?

Mr. **Zimmerman**. At this point in time, I believe we are, Mr. Chairman. I am not aware of any situation that has prevented us.

Chairman **Stark**. I would just like to encourage you to let this committee know if you're not because, in a sense, you're helping us oversee this, and I want to encourage whistle blowing before the situation gets out of hand.

How are we going to know, or how can we get records on adverse selection? In other words, one of the potential problems that I see, and I think you agree with, is that we could end up with a two-tier system, not necessarily based on economics, but we could have various providers skimming the cream and leaving us with the sicker Medicare beneficiaries who are costing the system a good deal of money.

How do we know we've got a handle on that?

Mr. **Zimmerman**. Well, let me say that it could be a combination of two factors. It could be a situation where providers are skimming, as some people may suggest, or just because of the general inclination of the population who are the healthier to go in a situation where it looks like it would be more economical for them and, on the other hand, have the people who are in more need of health care stay with it, trying two arrangements with existing providers.

I think this is obviously a major challenge here to the success of this program if its objective is to save money for Medicare. And I think, up to this point in time, it's a big question mark as to whether it is doing it.

I don't know whether Mr. Stropko is aware of any current initiatives on the part of the administration to get additional and better data.

Mr. **Stropko**. There are a number of initiatives right now. Getting an AAPCC that can accurately predict health care costs, though, has some natural constraints. I don't think that anyone assumes that the AAPCC, by itself, is actually going to solve the problem bias selection. There are, however, a number of ways of improving the AAPCC's predictive ability that are being tested by HCFA and others right now. These involve looking at prior levels of beneficiaries' health care before they enroll in an HMO, looking at certain diagnostic information that can be obtained from the automated files, and by using various forms of beneficiary health status questionnaires.

All these factors, taken together, however, are likely to account for, at best, perhaps 20 percent of the variance in health care expenditures. And there's a lot of variance.

So HCFA is probably going to have to consider some administrative remedies as well to increase the accuracy of HMO payments. These could involve such things as reducing the HMO's involvement in the beneficiary enrollment process and perhaps sometime down the road, taking a look at locking beneficiaries into an HMO for some period of time, as most of us are locked into our insurers for a year.

Chairman **Stark**. I'm going to ask you for a normative answer here, which I know is beyond the requirements of your agency's charge or your job descriptions.

But in your reviewing costs for our Medicare system in general, which you do in addition to these specific things, professional fees, procedures that are beyond the DRG, blood tests or general costs, is there any one area that you have observed that stands out among all others as costing the system an unnecessary large amount of money, or causing more of our increasing costs which seem to be going up, 13 percent or so each year?

Is there any one area that either of you would pick out and say go for that first, that's where you're hemorrhaging?

Mr. **Zimmerman**. Well, off the top of my head, I would say physician services in general. I mean you don't go into a hospital without the involvement of a physician; you don't have a lab test without the involvement of a physician; and you don't have a physician charge without the involvement of physicians.

So I say generally, looking at the overall utilization of physician services is where I would focus my attention. I do not want to call it the original sin but, you know, that's where it all begins. And without physician services and physician visits, you don't have a beginning.

Mr. **Stropko**. Sounds good to me.

Chairman **Stark**. I want to thank both of you gentlemen and, as usual, the committee looks forward to continuing to work with you on these projects and on the problems.

Thanks a lot.

Mr. **Zimmerman**. Thank you.

Chairman **Stark**. Our next witness will be Dr. Joseph Newhouse, the senior fellow with the RAND Corp.

Dr. Newhouse, welcome to the committee. We have your prepared testimony which, without objection, will be placed in the record in its entirety.

Please feel free to summarize it or expand on it in any manner you're comfortable.

Welcome to the committee.

STATEMENT OF JOSEPH P. NEWHOUSE PH.D., SENIOR CORPORATE FELLOW, THE RAND CORP., SANTA MONICA, CALIF.

Mr. **Newhouse**. Thank you very much, Mr. Chairman, for inviting me here.

I will try to summarize what I have in about 10 minutes and answer any questions you may have.

What I have written here are my own views and not necessarily those of the RAND Corp. or the sponsors of its research, especially HCFA. The research upon which the testimony is based has been supported by HCFA through its research center that it supports at RAND and UCLA.

I want to talk about improving the method Medicare uses to pay health maintenance organizations and competitive medical plans. I'm just going to refer to them simply as HMO's for ease of nomenclature.

As has been said by the previous witnesses, the cornerstone of the current method is the adjusted average per capita cost, the AAPCC. The growth in Medicare enrollments in capitated plans has highlighted certain inadequacies in the AAPCC.

It didn't really matter very much when only a tiny fraction of Medicare beneficiaries were enrolled in HMO's but, as you know, that situation is rapidly changing.

Although henceforth I'm going to talk entirely about Medicare, I do want to note in passing that the same situation applies to Medicaid beneficiaries who are enrolled in HMO's. In fact the method that most States use to reimburse HMO's for Medicaid beneficiaries is even less sophisticated than the AAPCC.

Now, as has been said, the intent of Medicare is to pay the HMO what Medicare would have paid for those beneficiaries had they sought their care in fee for service. To do that, Medicare begins approximately with the average per capita cost in the beneficiary's county of residence, as has been said, and then adjusts those costs for age, sex, welfare status, institutional status, and whether the beneficiary has disability insurance or end stage renal disease. All those adjustments give rise to the first A of the AAPCC.

The basic problem is that these adjustments are very minimal. Medicare in effect pays the same amount for a 70-year old woman with cancer of the lung as it does for a 70-year old woman who is free of chronic disease, even though the costs of treating the one are obviously likely to be much greater than the cost of treating the other.

This sameness of payment creates if sick or expensive enrollees are opting preferentially for one type of system, either HMO's or fee for service, or if one type of system is opting preferentially for them.

As you and the other committee members have noted, those HMO's that attract fewer expensive patients over time are going to prosper relative to others and conversely. And this possibility, as has been brought up here, hasn't escaped the eye of the Congress or the eye of DHHS and HCFA, which has written regulations about skimming and dumping.

I do want to point out that even a little dumping can have a dramatic effect on the bottom line if an HMO cares to engage in it. About a quarter of the Medicare dollars are spent on the top 1 percent of enrollees, about half are spent on the top 5 percent.

Not all those expenses are predictable, and if an HMO is going to engage in this, it really needs to predict the expense. But some expenses are predictable. So patients who are predictably in the top percentiles are like the queen of spades in a game of hearts. Nobody wants to wind up with them, from a fiscal point of view anyway.

Because there are so few individuals that are high cost, and because there's a considerable turnover for quite innocuous reasons in a year in a HMO, it's really quite difficult to detect dumping. That's not an argument against the regulations and their enforcement. It's rather an argument to try to improve the AAPCC so we have less of a problem that we're up against.

Improvements would have at least three benefits:

First, the access to care by costly patients, that is the willingness of an HMO to treat them, should be improved. There is not a financial incentive to shuffle the patient on down the street. And, conversely, the burden that the regulations have to bear is less.

Second, HMO's who, through no action of their own, find they have enrolled a costly group of beneficiaries will not be disadvantaged. This is, I think, especially important for small HMO's. In the case of large HMO's who are not trying to skim or dump, the costly patients should average out.

Third, the cornerstone of the AAPCC is the so-called U.S. per capita cost, the average cost throughout the country in fee for service. If a nonrepresentative group remains in fee for service, then even that figure can be distorted. There was obviously not a problem when HMO enrollment was under 1 percent, but now we have to face the issue that even it may be getting distorted. An example of the problem is a place like Minneapolis-St. Paul where Medicare penetration is over 50 percent. Then it's essentially a leap of faith that the individuals who are left in fee for service, the minority, are like those who have opted for HMO's.

Chairman STARK. Are you not suggesting that those people in the HMO's tend to be less sick?

Mr. NEWHOUSE. Well, I'm just saying if they are, then the whole structure is distorted. And as was brought up, the Federal Government payments are going to be inflated by that.

Chairman STARK. Well, I go now to one of the cities in my district where, as a practical matter, Kaiser has half the Medicare benefits—half the people in this particular city of Hayward are members of the Kaiser plan, for whatever reasons. Historically, they were handling union negotiated plans and people stayed on.

And I would guess that's the healthiest half of the population. I suspect that in the other half are those people who were too poor to have insurance while they were working and didn't have regular medical attention that was available under a good HMO like Kaiser.

And, therefore, you've got a highly—and as was witnessed by my earlier testimony—and a very tough screening processed if you want to join Kaiser as an individual. You can't smoke and, you can't drink. By now, it's probably blood tests and EKG's and a regular insurance physical. Therefore, they're not going to get many of the other sicker half.

Don't those kinds of situations sort of screw up this measurement here? Don't we get a terrible adverse selection in those areas?

Mr. NEWHOUSE. Well, it's not certain that you will get an adverse selection. There's clearly some incentive to engage in it, and if that incentive is followed through on, then there's a problem. And the problem—as HMO enrollment grows, the problem is going to spread to the whole calculation of the country's average.

Chairman STARK. Thank you.

Mr. NEWHOUSE. Let me talk a minute about where to go from here in terms of improving matters.

The route, of course, is to add adjusters to the formula to take account of the characteristics of the individual in terms of how expensive that individual is likely to be to treat. There are two types of measures that are usually talked about.

One set is the various measures of health status, and the other is the measures of prior utilization.

There is also a possible adjuster for prior eligibility for disability insurance, but that's a minor adjuster.

Research I have undertaken with others at RAND with HCFA support has shown that adding health status measures is going to help, but it's only going to get us part way, I estimate it will get us about a quarter of the way to where we would like to get, albeit that's a substantial gain over where we are.

I will work through an example of why this seemingly good idea doesn't work better. To do so, I take as a measure blood pressure, which, on the face of it, would seem to be a good measure, both because among the class of health status measures, it is relatively cheap to measure, and because we know it's predictive of future cardiovascular disease. If one has a high blood pressure, one is at greater risk.

The problem from the point of view of reimbursement is that fortunately, medical care can do something about blood pressure at a cost. If one takes one's drugs, one's blood pressure will be controlled. So one person may have blood pressure controlled through medications, say at 90 millimeters of mercury diastolic, where as another one has a natural blood pressure of 90 millimeters of mercury.

So, if one puts blood pressure in the payment formula, it's going to pay the same amount for those two people even though one is clearly more expensive to treat than the other.

What one would like to observe is the person with uncontrolled pressure, but one can't observe that, and one wouldn't even want to try because that would be a risk to the person.

Now, because of these problems of measures of health status, I've also looked at prior utilization. That's more promising, because if one has used a lot of services in the past year, one is more likely to use services the next year. Some kinds of prior utilization are more predictive of future costs than other kinds. That's the main idea behind the diagnostic cost groups method that Arleen Ash and her colleagues at Boston University have developed. That has been referred to in some of the prior testimony. I support a demonstration of diagnostic cost groups a demonstration which I think HCFA is contemplating. But I would emphasize that this is a very—at this point in time—first-cut method and that more refinement of it is certainly going to be worthwhile.

I also agree with the previous witness that, in effect, there's some natural constraints, as he put it, on the AAPCC. Another way to say that is the ability of past utilization to predict these costs also falls short. I think that measures of past utilization, if we included them, might get us about two-thirds of the way to where we want to go. If we want to get past that point, I think we have to contemplate using what I've termed a blend of the actual use of services in a year with a capitated rate.

For example, one might base two-thirds of the payment on an improved AAPCC, one that brought in diagnostic cost groups, for example, and one-third might be based on what a fee-for-service provider would have been paid for the set of services that the HMO delivered.

There are at least two problems with such a proposal, although one of those problems I think is only an apparent one. The apparent one is that some people think that any introduction of fee-for-service incentives is wrong. I don't think that's the case. The basic argument is pretty easy and was brought up earlier. People worry about "overdoctoring" with fee for service; they worry about "underdoctoring" with capitation.

If both of those fears are right, something between the two ought to be better. And, in fact, once we start talking about introducing an adjustment for prior use, we've already got an element of fee for service in the formula. So I think that's an apparent problem.

But I think the real problem is that HMO's are not prepared to implement a method that bases part of their payment on the actual services delivered. That's especially true of the group and staff model HMO's with respect to outpatient services. That too was mentioned earlier.

So if we are going to have a blended payment method, there are going to have to be some costly investments in data collection. On the other hand, it seems to me that a well-managed plan would want to know which providers were delivering which services to which patients, both for purposes of monitoring costs and for purposes of monitoring quality of care. So I don't think that we are talking here about something that's a pure waste, if you will, in terms of administering a reimbursement system.

I suspect that in fact more and more HMO's are going to acquire the capability of doing this over time, but maybe there should be a demonstration project to grease the skids.

Let me try to sum up. First, a potentially important problem of the AAPCC is its failure to account adequately for the variation across individuals in their expected costs. The present set of adjusters, age, sex, welfare status, and institutional status, is better than nothing at all, that is just using the average, but the quantitative gain over just using the average isn't very large.

Second, introducing measures of health status will improve matters, but it's costly, and it seems unlikely to remedy the problem.

I think the most promising short-run strategy is to introduce measures of utilization into the formula, as HCFA proposes to do with its demonstration of the diagnostic cost group method. That's one way to do it.

A promising step for the intermediate run would be to base only a portion of the HMO's reimbursement on the AAPCC, and base the remainder on the nature of the actual services delivered. At least that's something one could do while one is working on refining the AAPCC further, but it would require a data collection system that ascertained which services were actually delivered.

Finally, I think supporting research and demonstrations on refining the AAPCC is very important as Medicare enrollment expands in capitated plans.

[The statement of Dr. Newhouse follows:]

TESTIMONY OF JOSEPH P. NEWHOUSE
BEFORE THE SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON WAYS AND MEANS, HOUSE OF REPRESENTATIVES
ON MARCH 10, 1988

Mr. Chairman, Members of the Committee, thank you for inviting me to testify. I should emphasize that what I am about to say represents my personal views and not necessarily those of my employer, The RAND Corporation or the sponsors of its research, most notably the Health Care Financing Administration. The research upon which my testimony is based has been supported by the Health Care Financing Administration, through the research center it supports at RAND and UCLA.

I wish to talk today about improving the method Medicare uses to pay Health Maintenance Organizations and Competitive Medical Plans. For simplicity I shall simply refer to them as HMOs. As you know, the cornerstone of the current payment method is the Adjusted Average Per Capita Cost, or AAPCC. The growth of the number of Medicare beneficiaries in capitated plans has highlighted certain inadequacies in the AAPCC. These inadequacies were of little import when only a tiny fraction of Medicare beneficiaries were enrolled in HMOs, but that situation is rapidly changing. Although I will speak entirely about Medicare, I note that the same issues arise in conjunction with reimbursement for Medicaid beneficiaries who are enrolled in HMOs; indeed, the methods states have adopted to reimburse HMOs for Medicaid beneficiaries are generally less sophisticated than the Medicare method.

The intent of the current Medicare method is to pay the HMO what Medicare would have paid for its beneficiaries had they sought their care in the fee-for-service system. Some may question the appropriateness of using a fee-for-service standard, but I shall not. Because it would seem incompatible with a free choice of system to have one standard of care for fee-for-service beneficiaries and another for HMO beneficiaries (most would opt for the higher standard of care), those who argue that fee-for-service should not be the standard either have in mind a situation in which there is no choice of delivery system or a situation in which the fee-for-service standard is changed, with HMO reimbursement continuing to conform to the new fee-for-service standard. I shall assume that we will continue to have choice, and that HMO reimbursement will continue to be based on a fee-for-service standard.

To compute what Medicare would have paid if an HMO member had been enrolled in the fee-for-service system, Medicare begins (approximately) with the average per capita costs in the beneficiary's county of residence. It then adjusts those costs for the beneficiary's age and sex, as well as whether the beneficiary is eligible for welfare, is institutionalized, and is disabled or has end stage renal disease. These adjustments give rise to the first A of the acronym AAPCC.

The problem is that these adjustments are very minimal. In general, Medicare pays an HMO the same amount for a 70 year old woman with cancer of the lung as it does for a 70 year old woman who is free of chronic disease, although the costs of taking care of the former woman are likely to be much greater than the costs of taking care of the latter woman. This creates a problem if sick enrollees are opting preferentially for one type of system or if one type of system is opting preferentially for them.

Some sick enrollees will prefer HMOs, perhaps because they feel their out-of-pocket payments will be less; some will prefer fee-for-service, perhaps because they have an established physician relationship that they are reluctant to sever. Although each system of care will appeal to some, it is unlikely that the proportion of expensive-to-treat patients in a given HMO will be the same as in other HMOs or in fee-for-service. And those HMOs that attract fewer sick patients over time are likely to prosper relative to others and conversely.

The possibility of an HMO's making money by enrolling disproportionately healthy beneficiaries has not escaped the eye of DHHS, which has written regulations with respect to non-discriminatory enrollment and sanctions if costly-to-care-for patients are "dumped." Nonetheless, even a little dumping can have a dramatic effect on the bottom line if an HMO cares to engage in it. About a quarter of the Medicare dollars are spent on the top 1% of enrollees, and around half are spent on the top 5%. Not all of these expenses are predictable, of course, but some are. Patients who are predictably among these top percentiles of patients are like the Queen of Spades in a game of Hearts; from a fiscal point of view no HMO wants to end up with them.

Because there are so few individuals who are high cost, and because there will be a considerable number of individuals in any one year who elect for quite innocuous reasons to leave an HMO, it is difficult to detect efforts by an HMO to subtly persuade an individual to enroll in another plan. This is not an argument against the anti-dumping regulations and their enforcement; rather it is an argument to improve the AAPCC formula so that the incentive to select healthy (i.e., inexpensive to care for) patients is less. By improving the formula, I mean that the reimbursement for a patient at the beginning of the year would more closely correspond to the costs that an HMO might incur by treating that patient (technically the expected costs of treating the patient).

Improvements in the formula would have three benefits:

1. Access to care by predictably costly patients should be improved. There would not be a financial incentive to shuffle such a patient down the street; correspondingly, the burden on enforcing the anti-dumping regulations would be lessened.

2. HMOs, who through no action of their own find that they have enrolled a costly group of beneficiaries, will not be disadvantaged.

3. The cornerstone of the AAPCC calculation is the so-called USPCC, the United States Per Capita Cost. This is the average amount Medicare pays per beneficiary in the entire country, including HMO beneficiaries, but because the HMO beneficiaries are paid at a rate equal to fee-for-service, this amount is effectively a function of the amount paid for fee-for-service enrollees. If a non-representative group remains in fee-for-service, the USPCC can be distorted. The scope for distortion is minimal when HMO enrollment is 1 percent or less, as was the case for the first fifteen years of the Medicare program, but now the enrollment is climbing and with it the possibility that the USPCC might be distorted. This raises the possibility of having to adjust the USPCC.

A foretaste of the problem comes in areas that have high HMO penetration such as Minneapolis-St. Paul, where over half the Medicare beneficiaries are in HMOs. In the calculation of the AAPCC the USPCC is multiplied by ratio of the county per capita cost to the USPCC (the ratio is averaged over the last five years). The county per capita cost is a function of the costs incurred by the Medicare beneficiaries who have remained in fee-for-service. In areas like Minneapolis-St.Paul with high HMO penetration, it is a leap of faith that the minority of beneficiaries who have remained in the fee-for-service system are like those who have not.

What then are the technical possibilities for improving the AAPCC? And by how much might the AAPCC be improved? There are several criteria one can use for judging the AAPCC's performance. The most common is the amount of variation in expenditure that the AAPCC accounts for, or what a statistician calls R-squared.

One cannot predict all expenditure; heart attacks, automobile accidents, and falls all have an element of unpredictability about them. Nonetheless, some people are at higher risk than others of heart attacks, accidents, falls, and other medical events and they will correspondingly have higher expected costs. (The situation is analogous to adolescent males being at higher risk of an automobile accident and so being more expensive to insure.) I and others have estimated that around 15 to 20 percent of the variation in expenditure, perhaps more, is predictable; that is, if we could predict expected cost across people, we would explain about 15 to 20 percent of the variation in actual expenditure. Unfortunately, the current AAPCC explains only around 1 percent of the variation. This is a quantifiable way of expressing the qualitative problem that the AAPCC pays the same for the 70 year old woman with cancer of the lung as it does for the 70 year old woman who is free of chronic disease.

The route toward improvement is to add adjusters to the formula in order to explain better the variation across individuals in expected cost. The two generic types of adjusters usually proposed for addition to the current list are measures of health status and measures of prior utilization. (One other adjuster that has been mentioned in the literature is eligibility for disability insurance. I favor adding this measure, but adding it would only represent a small improvement.)

Research I have undertaken with others at RAND with HCFA support shows that including measures of health status in the formula would improve matters, but is unlikely to resolve the problem. In particular, we estimate that measures of health status, together with the currently included measures such as age and sex, would only get us about a quarter of the way to where we want to get, albeit that is a substantial improvement over the present situation.

A number of problems, however, would arise in trying to include measures of health status. For concreteness, let us imagine that we include a measure of blood pressure in the formula. Blood pressure seems like a good measure to include because it is known to be predictive of future cardiovascular disease.

The first problem with including blood pressure is that it would be relatively costly to collect and audit the information (and among health status measures, blood pressure is a relatively cheap measure to collect). An even more serious problem arises because optimal medical care should be able to control high blood pressure but at a cost. Including blood pressure as an adjuster would have gained nothing if the reimbursement formula paid the same amount for two individuals who were alike, except one has an uncontrolled diastolic blood pressure of 90 mm Hg and one has a controlled (through medications) blood pressure of 90 mm Hg. Simply including blood pressure in the formula would not trigger differential reimbursement, even though the cost of caring for the second person is greater than caring for the first. One could, of course, pay more for individuals who were under treatment for high blood pressure, but even this would not address the higher costs of the individual who had a more severe problem and who needed more frequent monitoring to achieve a blood pressure of 90 mm Hg. Blood pressure is merely an example; the same problem arises in any disease that responds to treatment and in which a more severe underlying problem dictates more costly treatment. This problem also applies to measures of self-reported health status, and in addition self-reported measures are potentially vulnerable to fraud.

More promising adjusters are measures of prior utilization. Individuals who have used many services in the past year are more likely to use services in the subsequent year. Moreover, some kinds of prior utilization are more predictive of future cost than other kinds. This is the main idea behind the Diagnostic Cost Groups that Arleen Ash and her colleagues at Boston University have developed. I support a demonstration of Diagnostic Cost Groups, but I think the current version is likely to prove only to be a promising first step; more refinement of this technique is likely to prove worthwhile.

My own research suggests that the ability of past utilization to predict expected cost also falls short. It is uncertain just how far it falls short, but I estimate (using a sample of adults under 65) that measures of past utilization might explain around two-thirds of the explainable variance. As an example of the problem, the Diagnostic Cost Group

method pays an HMO more if an enrollee had a certain kind of hospitalization in the previous year. Such a method, however, does not address the heterogeneity within diagnostic categories; the problem is analogous to the heterogeneity within DRGs in the Prospective Payment System.

Further improvement can come from using a blend of actual use and a capitated rate. For example, two-thirds of an HMO's payment might be based on an improved AAPCC, one for example that included Diagnostic Cost Groups, and one-third might be based on what a fee-for-service provider would have been paid for the set of services that an HMO delivered to its patients.

There are at least two problems with such a proposal, one apparent and one real. The apparent problem is that some will believe any introduction of fee-for-service incentives is wrong. But this is not the case; it depends on the size of the fee. Pure capitation is a zero fee for additional work; this clearly minimizes the incentive to do even appropriate additional work. This argument can be made another way: Although many worry about "overdoctoring" with pure fee-for-service, others worry about "underdoctoring" with pure capitation. If both fears are right, something between the two ought to be better. Moreover, basing part of next year's payment on this year's use, as the introduction of measures of prior use into the formula does, already introduces a non-zero fee for additional use; receipt of the monies is simply delayed for a year.

The real problem is that most HMOs are not prepared at this point in time to implement a method that bases part of their payment on actual services delivered. This is especially true of group and staff model HMOs with respect to outpatient services. For many, I daresay most, such HMOs to implement such a method would require costly investments in data collection. On the other hand, it seems as if a well-managed plan would want to know which providers were delivering which services to which patients, for purposes of monitoring both costs and quality of care. I suspect that over time more and more HMOs will acquire the capability of providing such data, but perhaps a federally supported demonstration of its cost and value would grease the skids.

There are other issues with respect to improving the AAPCC that I will not go into today. Among these are: 1) The amount of data that is available to HCFA actuaries at the point in time when they must estimate what fee-for-service costs are (this is partly a problem of the lag in claims, partly the timing of the estimate, and partly the difficulty in estimating the consequences of the changes that Congress is making in the Prospective Payment System and in Part B) and 2) The use of the county as a geographic unit for defining the AAPCC. I believe improvements are possible in both areas, but that these issues are not as pressing as that of improving the ability of the AAPCC to predict an individual's future costs.

I would like to close by addressing the Average Community Rate (ACR), which was designed to partly mitigate the problems I have been discussing. The ACR is based on rates an HMO charges for its private business, adjusted for differences between the privately insured population and the Medicare population. The law provides that if 95 percent of the AAPCC exceeds the ACR, the difference must be used to provide Medicare enrollees additional benefits or reduce their cost sharing (or be returned to the government).

Such a cap even in principle does not reduce the financial incentive for an HMO to shun a sickly Medicare beneficiary, but it does purport to address the problem of "too high" an AAPCC by a link to the HMO's private rate. Even in principle, however, that link does not reduce the federal payments from a "too high" AAPCC; the excess flows through to the beneficiaries.

More importantly, in practice as opposed to in principle, there appears to be a serious problem with adjusting the ACR for differences between the privately insured population and the Medicare population. These problems relate to both differences in demand for care by age group and differences in the medical benefits covered.

Persons over the age of 65 use about three times as much medical care as those under 65; clearly any premium for Medicare beneficiaries that is based on the under 65 must account for that difference. But it is difficult to apply the factor of three to any given HMO, because either the non-elderly or the elderly or both that it enrolls may be unrepresentative. Therefore, in practice this adjustment has been made on the observed use of the elderly relative to the non-elderly within an HMO. An HMO faced with an ACR that is less than 95 percent of its AAPCC could simply choose to deliver more services to its elderly. This will cause its ACR will rise, but has the same ultimate effect as passing "excess profit" through to the beneficiaries. The problem is that the HMO also has an incentive to somewhat reduce services to the non-elderly, in which case the effects are quite different.

The problem in differences in the medical benefits covered relates to services that are primarily used by one age group or the other. Take first a service that is mainly used by Medicare beneficiaries, perhaps home health services. It is simply not clear what the analogous cost for an HMO's private business is, but in any event the HMO has ~~an~~ incentive to allocate as many overhead type costs to such a service as possible. By the same token, it has an incentive to allocate such costs away from services such as the delivery room or the outpatient pharmacy that Medicare does not cover.

So, to sum up:

1. A potentially important problem of the AAPCC is its failure to account adequately for the variation across individuals in their expected costs. Although the present set of adjusters is better than no adjusters at all, that is, better than simply using the average cost per person to reimburse an HMO, the quantitative gain over no adjusters at all is not very large.

2. Introducing measures of health status as adjusters will improve matters, but is costly and seems unlikely to remedy the problem.

3. The most promising short-run strategy is to introduce measures of utilization into the formula, as HCFA is proposing to do with its demonstration of the Diagnostic Cost Group method. This particular method, however, is very much a first-generation method. A promising step for the intermediate run would be to base only a portion of the HMO's reimbursement on an improved AAPCC and base the remainder on the nature of the actual services delivered to a given individual. At a minimum, this seems like a step that could be taken while more refined

methods for computing a capitation rate are being developed. It would, however, require that group and staff model HMO's collect more data on outpatient use than most of them now do. Such data, however, should have value in managing the plan, and so the cost of collecting them should not be viewed as a pure cost of the reimbursement system.

4. Refinement of the AAPCC through additional research and demonstrations is important as Medicare enrollment in capitated plans expands.

Chairman **Stark**. Go over for me in the simplest way the idea of the blended rate, which I gather is adding on a fee for service to an HMO?

Mr. **Newhouse**. I've used weights of two-thirds and one-third here as an example, and one would have to do some more work on what weights use. But let's take those for convenience.

Suppose we start with the current AAPCC method. We can work on improving it, and we could——

Chairman **Stark**. And that's just taking the rate in an area of the average cost per person.

Mr. **Newhouse**. Yes, but its adjusted it for age and sex and welfare and so forth. And we could potentially improve it by taking account of other things, like were you hospitalized for cancer last year? And the HMO you gets a higher payment if you were. That sort of thing.

Chairman **Stark**. Let me see if I understand this.

Let's say you've got an HMO with 100,000 members, and we've got an AAPCC and we pay them 95 percent of that per head. OK. Now you're suggesting that we, at the end of the year, or some point, add up everything that the HMO did. I would presume you'd take all the doctors' fees that are approved for approved procedures, and all the DRGs, payments for the hospital admissions and the tests that are approved, and add them all up?

Mr. **Newhouse**. Yes.

Chairman **Stark**. And then you get it blended, and if you added a third of that you'd raise or lower the amount depending on the type you used?

Mr. **Newhouse**. Right. One could use some interim payments, particularly for cashflows—but you're right, that's the basic idea.

Chairman **Stark**. OK. All right.

Would it not be simpler, because earlier you suggested that we have basically 1 percent, which to me almost indicates an outlier, because it's the real financial burden on the HMO, to just refine the outlier system, or am I missing something there?

Mr. **Newhouse**. No. The outlier system, remember, is already fee for service. There's no outlier system for the HMO per se.

Chairman **Stark**. But aren't you really sort of suggesting that?

Mr. **Newhouse**. Obviously, a lot of any fee-for-service payment would be in effect a payment for for outliers, you're right.

Chairman **Stark**. In particular, if the HMO is going to pick up any extra money under your proposal, wouldn't it probably be under some kind of an outlier reimbursement?

Mr. **Newhouse**. Right. Of course, it could could also get less money if it's enrolling primarily healthy people.

Chairman **Stark**. This isn't very scientific. But it sounds to me like you could construe, and I gather we don't have the data, to say, sure, HMO's or capitation are going to save us money as long as we don't get hooked with too many outliers going into the HMO system, in which case we're losing them.

Mr. **Newhouse**. It's actually the outliers in fee for service that will up Federal payments to HMO's because if they are disproportionately in fee for service, that will up the fee-for-service average which will in turn, up the HMO payment through the AAPCC.

Chairman STARK. If we get them into an HMO, do we avoid the outlier?

Mr. NEWHOUSE. Well, then you get the issue——

Chairman STARK. Or cost.

Mr. NEWHOUSE [continuing]. That the HMO has the incentive to try to get them in to somebody else's HMO. And I'm trying to address that incentive.

Chairman STARK. And if it's obvious to me, then the gatekeeper at the HMO is going to understand that in spades? I mean if I can figure that out, think what a person who does this for a living could do.

Mr. NEWHOUSE. Well, even if an HMO thought it was unethical to do that, somebody else may come in who decided it wasn't.

Chairman STARK. It seems to me that ethics are quantifiable.

Mr. NEWHOUSE. Yes. But we do have the example of where Blue Cross was in effect knocked off of community rating when commercial insurers entered in the postwar period.

Chairman STARK. I have heard it suggested that the only way to break the fee-for-service spiral is capitation. That is not my intent. One would suspect from the behavior of the AMA that it would be, but it really isn't.

But what it really looks like to me is if the capitation program is going to be subtle discrimination, it's going to define the really profitable or successful nonprofit HMO?

Mr. NEWHOUSE. You're right, and that's really why I'm trying to blunt that very sharp incentive.

Chairman STARK. Should we, just as a good policy, be saying that we want to use the HMO's because, by putting this potential outlier in an HMO as early as we can, we're going to get them the kind of care, preventive care or early detection that will minimize the cost of the outliers as the people get older?

What I'm worried about is a funny set of incentives all focused around profit in what has historically been a "nonprofit environment." And we all know what the problem is. It's the 1 percent of people who get very sick and have a high capital cost requirement.

Mr. NEWHOUSE. Right.

Chairman STARK. And it seems to me that what we're really doing, is shuffling them around.

Mr. NEWHOUSE. Well, there's no doubt that the present method has that incentive.

Let me make an analogy for you. In effect, what we have with pure capitation is a fixed price for a heterogeneous product, namely a mix of patients. The analogy I want to make is, when you go to the supermarket and observe people rolling their carts down the aisle, when they go by the breakfast cereal or they go by the soft drinks, they just reach for any box, you know, as long as it's Cheerios or whatever they want, and they throw it in the cart. When they get to the produce, they take more time, sifting through to look whether the bananas are too ripe. A lot of people do this. If you think about what bananas get left on the stand at the end of the day relative to what boxes of Cheerios get left on the stand at the end of the day, there's quite a difference. And, in effect, that's the kind of incentives we've got here.

Chairman **Stark**. My mother is not going to like being referred to as a banana. [Laughter.]

Mr. **Newhouse**. You know, we have a fixed price per pound of bananas, even though the bananas are heterogeneous. If we moved some away from that fixed price, so that overripe bananas cost less, we still may have a problem, but we'd have less of a problem. The point in the AAPCC case in to better aline the incentives with the cost of treating the person.

Chairman **Stark**. To really work, and I know this gets so far away from free enterprise that it's probably an obscene statement, but to really work, the capitation program almost has to be implied in a mandatory sense on a broad population. Then you've got to pay to get out of it or to get additional services as opposed to allowing some vaguely indeterminate system to select.

Because the incentives, whether they're monetary or just institutional or nonprofit, somehow you have to assume that nonprofits don't have the same incentives, I don't think I believe that, but——

Mr. **Newhouse**. I should warn you I come from a nonprofit institution.

Chairman **Stark**. I know that. And I suspect it has the same incentives as SRI, or Arthur D. Little, which is kind of a mirror of profitmaking image. I think that institutions take on a growth instinct of their own, regardless of their pride for your own colleague satisfaction and for enjoying the reputation that RAND has.

And the same thing must have happened in hospitals. Coming back to that, if you take a community, like the Twin Cities, and say, wait a minute, if it's really going to work, everybody should have to be in a capitation program. Then we figure out what we should do with the outliers. We either create leper colonies, or we make you keep the lepers and treat them within.

Mr. **Newhouse**. But even with everybody in an HMO then, you'd still have the problem that I'd like to get the outlier to somebody else's HMO.

Chairman **Stark**. Then it seems to me that the whole community is dealing with how we create outliers. In other words, you can't ignore the leper. You better look for a cure for leprosy. You can't ship them to the outer islands.

And you can't say that we're not going to take smokers. If you're running a program, you better do some heavy duty substance abuse programs, and include the smokers. Because if you're going to be judged on how healthy your community is, that's a really big problem, and you can't resolve it by, a shove in on the fee-for-service program side of the coin. It doesn't help us.

Your testimony is exciting and it's also disconcerting.

If there was any bit of advice about what this subcommittee ought to do in a couple of areas, like making data collection, is there any one particular area in which we ought to look for data?

In the area of costs—I always try to take quality as a given, as a constant in our equation—but in the area of costs, particularly escalating costs, and legislation, do you see any glaring rules that ought to be instituted right away? What would you tell us to do? What should our priorities be in your opinion?

Mr. **Newhouse**. I would just reemphasize what I said at the end of my testimony. I think a lot of work is needed, a lot of research is needed in this area, as well as demonstrations. The methodology we have is really fairly primitive. And one would think that improvements ought to be possible in it.

Chairman **Stark**. Thank you very much.

It will be the Chair's intention to work through the noon hour, and our next witnesses are a panel, which include Dr. Donald Berwick, pediatrician and associate professor of pediatrics at the Harvard Medical School, and vice president for quality of care measurement at the Harvard Community Health Plan, and Dr. William Moncrief, a thoracic surgeon and corporate director of the California Medical Review Corporation, the PRO for the State of California and the quality review organization for California, Arizona, and Hawaii.

Gentlemen, welcome to the committee. Dr. Berwick, would you like to proceed?

STATEMENT OF DONALD M. BERWICK, M.D., VICE PRESIDENT FOR QUALITY-OF-CARE MEASUREMENT, HARVARD COMMUNITY HEALTH PLAN, BROOKLINE VILLAGE, MASS.

Dr. **Berwick**. Thank you very much, Mr. Chairman. As I've listened to the testimony so far this morning, I realize that my remarks are going to be a little bit off-center from some of the issues that have concerned you so far. You've been talking largely about oversight and financial issues. My field of expertise is quality of care; in particular, the general mainstream quality of care in this country, and my testimony is directed to that issue.

I work for the Harvard Community Health Plan, as you said, which is the largest health maintenance organization in New England. It currently has about 365,000 members in eastern Massachusetts, and I also would say it has a Medicare risk contract.

Chairman **Stark**. How many members?

Dr. **Berwick**. 365,000 members. My department is called the quality-of-care measurement department. It was created in 1985 by the board of the HMO, and I was charged to develop and maintain internal information systems for the measuring, the monitoring, and the improvement of quality of care in service internally. Tools for doing this have generally not existed in and health care, as I think you know, and our work has therefore largely been developmental.

The assignment has given me a chance to observe and analyze issues in health care quality at close hand and to develop my own really personal theories and tactics for measurement and improvement. And it's those that I'd like to share with you today.

Let me state first the three conclusions that I have. First, I believe that health care quality can be defined and that it can be measured by those who are willing to devote the necessary time and resources to doing so. Second, I believe that American health care is very good, but I also believe it could be a lot better. In fact, I think there is enormous room, underestimated room, for the improvement of the technical quality, the productivity and the efficiency of health care in this country.

And that leads me to my third point. It is my opinion that a significant proportion of the current tone, techniques, tactics, effort that is occurring in this country for addressing health care quality issues is very unlikely to produce substantial improvements in care; in fact, I think it may be counterproductive.

Many industries other than health care have learned that a serious investment in continuous improvement of quality and service, guided by modern theories of quality control and quality management, can be the threshold to success in a globally competitive market. To our chagrin, the Japanese learned that first. The dividends can be enormous.

The important managerial and technical principles of modern quality improvement in other industries have yet to find their way into health care quality assurance activities. Instead, I think that in health care we are today replicating the types of error that put our domestic industries at a great disadvantage during a critical period of global competition.

Today the search for health care quality in our industry is grounded far too much in fear. We are multiplying forms of surveillance, of regulation, of discipline, of inspection, and of external accountability. Those efforts seem to me to be guided by the notion that substantial quality improvement depends mainly on discovering and eliminating defective producers, by catching people in the act of doing what they should not do, and by measuring enough that people and organizations simply cannot afford to err.

A modern quality control expert in any other industry would recognize in his own context that efforts like that are at the very best inefficient ways to enhance quality, and at the worst they are formulae for failure. They produce a market place of fear, they produce constant debate about measurement, not about quality, and they produce great distance between suppliers and purchasers and very wasteful tampering with systems and with people.

In Japan there is a saying in industry: Every defect is a treasure. To those who engage in the issue of quality for real in other industries, the search for ways to improve is continuous. The discovery of a deficiency creates the chance to do better what one has intended to do all along. In this modern and adaptive view, inspection is much less important as a tool for improvement; attention goes upstream into the process of production and design of production processes.

These ideas, I think, could extrapolate into health care, but when was the last time you heard a health care producer or a purchaser report that every defect is a treasure?

When quality is sought by discipline, by threat, and by regulation, people try to hide deficiency not to unveil it; they try to distort measurements, not to develop them; they try to prove to everyone else that they are good enough instead of finding out how to become better. Customers who are denied positive partnerships with those producers get angry, and the producers, who are beleaguered by assumptions that they are faulty become secretive, and every defect is a headache.

I think there is a chance to change. I think that if we are willing to change at least some of the emphasis from surveillance to improvement that we can achieve gains in quality and efficiency in the health care system. If we are going to do that, we will have to increase our level of understanding about the epidemiology of quality hazards, how quality fails; to develop better theories about how and when quality fails despite everyone's best intentions. We are going to have to develop a much clearer sense of joint purpose between health care producers and consumers, including the government, and realistic definitions of quality on which we agree. We are going to have to develop measurement systems not just for the purpose of surveillance and discipline, but for the purpose of developing better designs and better production processes.

I would like to see us put less stake into regulation and enforcement and more into trying to figure out how to improve what most of us in health care already want to do.

Thank you.

[The statement of Dr. Berwick follows:]

STATEMENT OF DONALD M. BERWICK, M.D., VICE PRESIDENT FOR QUALITY-OF-CARE MEASUREMENT, HARVARD COMMUNITY HEALTH PLAN

My name is Donald M. Berwick. I am a pediatrician, Associate Professor of Pediatrics at the Harvard Medical School, and Vice President for Quality-of-Care Measurement at the Harvard Community Health Plan. The Harvard Community Health Plan is the largest Health Maintenance Organization in New England, currently serving about 365,000 members in Eastern Massachusetts. My department, Quality-of-Care Measurement, was created in 1985 by the Board of the HMO, and charged to develop and maintain internal information systems for the measurement, monitoring, and improvement of the quality of care and service. Tools for doing this have generally not existed in health care, and our work has therefore been largely developmental -- inventing methods of practical use to managers, clinicians, and other decision makers.

This unusual assignment has given me the opportunity to observe and analyze issues in health care quality at close hand, and to develop my own theories and tactics for measurement and improvement. I appreciate this chance to share those views with you, even though they are based largely on a very local experience with one special form of health care delivery, the Health Maintenance Organization.

Let me state at the outset my three most important conclusions. First, I believe that health care quality can be both defined and measured by those willing to devote the necessary time and resources to doing so. Second, I believe that American health care is very good today, but also that it could be a lot better. In fact, I think that there is enormous room for improvement of the technical quality, productivity, and efficiency of health care in this country. Third, it is my opinion that a significant proportion of the current tone, techniques, and tactics for addressing health care quality issues today is unlikely to produce substantial improvements, and, in fact, may be counterproductive.

Many industries other than health care have learned that serious investment in the continuous improvement of quality and service, guided by modern theories of quality control and management, can be the threshhold to success in a globally competitive market; the Japanese learned that first. The dividends are enormous. In 1976, one American manufacturer was producing televisions with 146 defects per 100 units; 70% of their output was returned for repairs within 90 days; and employee turnover was 30% per year. With a change in management and the adoption of modern methods of quality improvement and control, by 1980 defects had fallen to 4 per 100 televisions, returns for warranteed repairs were 7%, and employee turnover was 1%.

The important managerial and technical principles of modern industrial quality improvement have yet to find their way into health care quality assurance activities. Instead, we in health care appear to be replicating the types of error that put our domestic industries at a disadvantage during a critical period of global competition. Health care is, of course, different in many respects from other industries, but we should learn what we can from these other lessons in quality improvement. American health care has no Japan to awaken it, but the pressures are building from within to improve quality and productivity.

Today, the search for health care quality is grounded too much in fear. We are multiplying forms of surveillance, regulation, discipline, inspection, and external accountability. Our efforts seem guided by the notion that quality improvement depends mainly on the discovery and elimination of defective producers, by catching people in the act of doing what they should not do, and by measuring enough that people and organizations cannot afford to err.

A modern quality control expert would recognize in any other context that such efforts are at best inefficient ways to enhance quality and at worst formulae for failure. They produce a marketplace of fear, constant debate not about quality but about measurement, great distance between suppliers and purchasers, and wasteful tampering with people and with systems. Perhaps these efforts do catch a few outliers -- thieves and incompetents -- but they lose much more in foregone opportunities for the improvement of the mainstream producer. That average producer is well-intentioned and wants to improve, but cannot afford to give up the defensive posture in so hostile a climate. With such fear, understanding cannot grow, and quality cannot generally improve.

In Japan, there is a saying: "Every defect is a treasure." To those who engage the issue of quality for real, the search for ways to improve is vital and continuous. The discovery of deficiency creates a chance to do better what one has intended all along to do. In this modern and adaptive view, inspection becomes much less important as a tool for improvement' attention shifts upstream to improving designs and monitoring production processes.

These ideas extrapolate easily into health care, but when was the last time you heard a health care producer -- physician, hospital, HMO -- or purchaser report that "every defect is a treasure?" The rhetoric of quality assurance at the moment -- negative, disciplinary, threatening -- makes that phrase seem laughable.

When quality is sought by discipline, threat, and regulation, people try to hide deficiency, not to unveil it -- to distort measurement, not to develop it -- to prove to others that they are good enough, not to find out for themselves how to become better. Customers denied positive partnerships with producers become angry; producers beleaguered by assumptions of their faults become secretive. Every defect is a headache. And so, when the Administrator of HCFA comes before a Congressional committee, he is asked not how the overall quality of care is being improved, but who has been caught in the act and eliminated.

If we are willing to chance the emphasis from surveillance to improvement, we can achieve enormous gains in both the quality and the efficiency of our complex and expensive health care systems. To do so, we will have to increase our understanding about the epidemiology of quality hazards, and to develop better theories of how and when, despite the best of intentions, quality can fail. We will have to develop a much clearer sense of jointly held purpose between health care producers and consumers, using realistic definitions of quality on which we all agree. We will have to develop measurement systems not for the purpose of surveillance and discipline, but for the purpose of designing and controlling better health care production processes. I urge that we put less of our stake into regulation and enforcement, and more of it into trying together to understand how to improve what most of us in health care already are working hard to accomplish.

(See appendix for additional information provided by the staff.)

Chairman STARK. Thank you. Dr. Moncrief.

STATEMENT OF WILLIAM H. MONCRIEF, JR., M.D., CORPORATE MEDICAL DIRECTOR, CALIFORNIA MEDICAL REVIEW, INC., SAN FRANCISCO, CALIF.

Dr. MONCRIEF. Thank you, Mr. Chairman. Written testimony has already been submitted to the committee, and I would just like to make a few brief oral remarks, and then answer any questions the committee might have.

California Medical Review, Inc., which is the quality review organization for California, Arizona, and Hawaii, represents about a little over 20 percent of the total Medicare beneficiary at-risk program in the Nation. And as such we are embarking on a new approach to looking at care, because for the first time the QRO is looking at a continuum of care.

Previously the PRO organizations were just looking at a small slice of health care delivery, which was in-patient care; but now we are looking at in-patient and outpatient care.

And also the HMO's have assumed a responsibility for managed care over a period of time, and this is what we are looking at.

I'd like to discuss briefly the perceptions that we have in California about what makes the program go. From the beneficiary's standpoint, we see at least in California, that it's the beneficiary with multisystem disease who enrolls in the risk-capitation program, the beneficiary who is seeing four or five physicians, who is getting reimbursement or trying to get reimbursement from the Medicare program after paying four or five physicians' offices, looking at a variety of explanation of benefits, EOB's. So this beneficiary, who, he or she, is a high utilizer of resources, comes into the risk capitation program to their advantage; for $25 or $30 a month, or whatever the premium might be, they don't have to do any of the paper work, they usually see most of their care delivered in one environment—there's less travel. So from the beneficiary's standpoint, they are motivated to get into it.

Congress obviously had the intent of recognizing the potential for underutilization or limited access in legislating this program, and also there was a certain incentive to contain the spiralling increase in health care costs, and I think this is the administration's approach to it.

As far as HCFA goes, I think there is an element in HCFA who really believes—and I think Dr. Roper is sincere that he is interested in quality of care to the Medicare beneficiary.

One of the things that we see, though, is that HCFA, in its enthusiasm to market the program has lost sight of education of the contractors—at least this is what comes out at the end. And the HMO industry, in its enthusiasm to recruit the beneficiaries, and particularly in its enthusiasm to market the program to the primary care providers, practitioners, or the gatekeepers—in this enthusiasm they have overlooked educating the subcontractor to his or her responsibilities. And more on that later.

The problems that we have faced so far in some 6 months of implementing the QRO program in these three States is that there is incomplete hospital data. There is little incentive for the hospital, under the HMO contract, to submit a bill, because the hospital is going to get paid whether it submits a bill or not. Without the hospital submitting a "no-pay" bill to the fiscal intermediary, the quality review organization has no idea that the beneficiary has been hospitalized.

As has been mentioned earlier, this lack of data spills over and is magnified in the ambulatory care or the outpatient encounter. There is very little data in this area, and particularly in the IPA model HMO, particularly the IPA model where the primary care practitioner or the gatekeeper is capitated, there is almost no incentive to document single doctor-patient encounters.

Another big problem is education of the beneficiary. I know it's been mentioned in earlier testimony that there is open enrollment, but the beneficiary must come to an orientation program, or have a patient support system that gets him or her to the orientation program. But if you sit in on most of these orientation programs—and I've sat in on a couple of them—the beneficiary's responsibilities are not clearly defined. It is strictly a marketing orientated program.

The cost of quality assurance is expensive. It's labor-intensive. And while HCFA has recently published—the Office of Prepaid Health has recently published its second draft of a model quality assurance plan—when I discussed this with medical directors of the HMO's in California, most of them say the guidelines are great, but we don't have the resources to implement it.

I don't think, in developing the AAPCC, that the cost of quality assurance was built into that at all.

One last comment I would make is about monitoring. The QRO's are monitored almost weekly in implementing their contractual responsibilities. I think that if the Health Care Financing Administration would monitor the HMO's and see that the HMO's monitored their subcontractors to the extent that the QRO's are monitored, the program would be much more effective and efficient.

Thank you, Mr. Chairman. Any questions.

[The statement and attachments of Dr. Moncrief follow:]

STATEMENT OF WILLIAM H. MONCRIEF, JR., M.D., CORPORATE MEDICAL DIRECTOR, CALIFORNIA MEDICAL REVIEW, INC.

My name is William H. Moncrief, Jr., M.D. I am a thoracic surgeon and corporate medical director of California Medical Review, Inc. (CMRI), the Medicare Peer Review Organization (PRO) in California and the Quality Review Organization (QRO) for California, Arizona and Hawaii.

I am honored to be here today to discuss CMRI's experience and perspective on the Quality Review Organization (QRO) program administered by the Health Care Financing Administration (HCFA) and implemented nationwide during 1987.

QRO contractors review the quality of the continuum of health services provided by risk-sharing Medicare Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) to enrolled Medicare beneficiaries.

CMRI, as the California PRO since 1984, has become nationally recognized and respected for its leadership in Medicare and quality review by the health care industry, the federal government and senior citizen advocacy organizations such as the American Association of Retired Persons. Last May, CMRI became the first PRO to contract with HCFA for the QRO program and became the QRO for the states of California, Arizona and Hawaii.

As one of the first organizations to implement the QRO contract, we have interacted with 16 Plans managing and delivering care in three states through both IPA and staff models. In addition, CMRI staff has developed an informal communication network with QROs subsequently selected to implement HMO/CMP review in other states. Based on this experience and communication, I would like to offer the committee some preliminary assessments and observations, including background information on development of the QRO program.

Specifically, I would like to provide you with a broad overview of the QRO program, including: a summary of the legislative history establishing the QRO program; an overview of QRO responsibilities as developed and designed by HCFA; CMRI's experience in program implementation; areas we have identified needing improvement; and possible solutions.

But first I want to emphasize the significance of the QRO program as an important milestone in quality assurance for the nation's approximate 981,000 Medicare beneficiaries enrolled in risk-sharing HMOs and CMPs. The QRO program marks the first time the federal government has attempted to monitor quality of care for complete episodes of illness, including care provided in the pre-hospital, hospital and post-hospital care settings. This comprehensive review is possible because the risk HMO/CMPs have accepted responsibility for the management of a system for delivery of necessary health care to Medicare beneficiaries. In addition, the QRO program includes a requirement to develop a focused review of ambulatory care, an area of care involving many more patient/practitioner encounters than inpatient acute hospitalizations.

The QRO program's expansion of review to settings outside of the acute hospital is a positive and a challenging step forward in the development of more effective quality assurance methodologies and processes. From the QRO experience, there is the potential to develop a uniform ambulatory data set, to identify more effective and efficient patterns of care, and to further enhance the effectiveness of the PRO as well as the QRO programs.

LEGISLATIVE HISTORY

To put the QRO program in context with the development of review programs for Medicare, I will review briefly the legislative history of the QRO program. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) which created the PROs, also enabled Medicare risk-sharing contracting with HMOs and CMPs. Congress recognized that this capitated reimbursement mechanism contained a potential financial incentive for underutilization. To assure that the inherent risks associated with these financial incentives do not negatively impact the quality of health care provided to beneficiaries enrolled in risk HMOs/CMPs, Congress included in the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA) an expansion of the PROs' responsibilities to review quality of care of services provided to beneficiaries enrolled in risk HMO/CMPs.

According to COBRA, the QROs were to begin review of risk HMO/CMP services by April 1, 1987. However, due to delays associated with the design of the Scope of Work, CMRI entered into a contract with HCFA effective June 1, 1987, requiring review to begin August 1, 1987 involving review of care provided through each plan on or after April 1, 1987. Due to a variety of obstacles that I will discuss later, CMRI did not actually initiate case review until November, 1987.

CMRI'S QRO RESPONSIBILITIES

Under CMRI's QRO contract, CMRI currently reviews services provided by 12 HMO/CMP plans in California; two in Hawaii and one in Arizona to more than 200,000 enrollees. Since initiation of review, two plans have not renewed their risk contracts and an additional plan has accepted a federal risk contract. Nationwide, QROs assess quality of care provided to some 981,000 Medicare beneficiaries in 133 plans.

The QRO activities consist of three elements of review: optional initial assessment upon the request of each HMO/CMP's internal quality assurance program to determine the level of review to be applied; retrospective review; and design and implementation of a focused ambulatory review program.

Assessment of a Plan's Internal Quality Assurance Program

At the onset of review each plan is assigned to the "basic" level of review unless it requests an assessment of the scope and effectiveness of its internal quality assurance plan. Following the assessment, if the QRO determines the plan's internal quality assurance system is effective and of sufficient scope, the QRO may assign the plan "limited" review. If the plan cannot fully demonstrate through documentation, production of records and outcome analysis, including corrective action, it will be assigned to "basic" review.

Although this review process is titled "initial assessment" in the Scope of Work, it is an evaluation that may be requested by a plan during the course of the QRO oversight period and under certain conditions. The advantages of undergoing this assessment are twofold. One, the plan has the opportunity for an external, confidential, objective assessment of their program's effectiveness without penalty and, two, there is the potential of reduced review requirements.

INITIATION OF REVIEW

Retrospective review of the continuum of care was to begin within 60 days of the effective date of the QRO contract. Prior to initiation of review each plan is notified of its assigned review level: limited or basic. Each plan is also informed that it may be reassigned to intensified review after any review cycle in which the number of problems identified triggers the need for increased scrutiny.

The specific QRO and Plan responsibilities for the three possible levels of review are described in attachment A; the "13 conditions" referenced in A are more fully described in attachment B.

DEVELOPMENT OF A FOCUSED AMBULATORY REVIEW PLAN

The third obligation of the QRO is to develop a review plan related to specific ambulatory care not associated with in-patient acute hospital care.

During the first six months of the contract, CMRI was to develop an "innovative and effective" approach to conducting ambulatory review. The purpose is twofold: to detect and correct problems in quality, appropriateness of setting or lack of access to care that result in or have the potential to result in an adverse outcome for the patient and also to explore review techniques which may be applicable to noncapitated care systems.

While we believe an ambulatory review plan will provide very useful information, efforts to develop this component of the program have been fraught with difficulty. The absence of a uniform ambulatory data base from which to identify patterns and select a focused sample of cases for review has prevented design or implementation of an effective ambulatory care plan to date. CMRI continues to strive to overcome this obstacle to develop an effective ambulatory review program.

IMPLEMENTATION EXPERIENCE

Precontract Award Activities

With the passage of COBRA legislation, CMRI leadership anticipated the potential complexity associated with review of care in capitated systems and recognized the concerns expressed by the HMO/CMP industry in California. To provide a foundation of open communication and to begin a professional relationship between CMRI and the industry CMRI organized meetings with the HMO/CMP administrators and medical directors in August and again in October, 1986 to review areas of mutual concern.

At these meetings, anticipated QRO review methodology was discussed with particular attention to the lack of accurate and complete data related to care provided in capitated systems. Most in the HMO/CMP industry readily agreed that there was little incentive within risk capitation systems to provide accurate data on health care services. Since a hospital stay for a risk patient is not related to a "DRG" payment, the incentive for compliance with submission of "no pay" bills for statistical purposes is lacking. The HMO/CMP industry recognized the need to improve this aspect of its contractual obligations. However, minimal discussion was directed toward identifying specific solutions for these problems at that time, since national compliance is necessary. These preliminary joint local discussions did much to allay anxiety on the part of both CMRI and the HMO/CMP industry, and made implementation of the program in 1987 somewhat easier, but by no means smooth.

Results of Initial Assessments

Immediately following award of the QRO contract to CMRI effective June 1, 1987 the 16 Plans to be subjected to external review were notified of their opportunity to request an "initial assessment". Of the sixteen Plans (twelve were in California, three in Hawaii, and one in Arizona), only nine requested on-site review to determine whether their review level would be Limited or Basic. These nine HMOs submitted required documentation to identify their established quality assurance programs in consonance with early guidelines from the Office of Prepaid Health Care, along with case listings for care already reviewed by each Plan. CMRI review of the documents submitted by the nine Plans resulted in five of the nine qualifying for an initial assessment. On-site review of medical records and documentation of Plan compliance with its stated quality assurance program resulted in only one of the five Plans being assigned to limited review; this decision meant that fifteen of the sixteen HMOs would undergo basic review with the start-up of the program.

The required scope of work for quality of care review of HMO/CMP Medicare risk contractors differs significantly from the required scope of work under the Medicare Peer Review Organization (PRO) program. The differences involve both the fundamental focus of review and the specifics of the review activities. Under the PPS program, the review focus involves both extensive utilization review as well as quality of care review. The proposed scope of work for risk HMO/CMP Medicare review has the sole focus on the quality of care, with utilization issues related only to access and timeliness of care.

Retrospective Review

Primarily due to the lack of data, implementation of retrospective review scheduled for August 1, 1987 was not begun until November, 1987. Volume of review of acute hospital care conducted remains under HCFA predicted levels but is improving as compliance with submission of UB-82s improves. Approximately 1,000 reviews have been conducted in California, Hawaii and Arizona to date. However, until there is a greater level of confidence in the accuracy and volume of claims submitted, reporting statistics related to the results of review would be premature in assessing the quality of care being delivered in a capitated system.

Focused Ambulatory Review

Lacking uniform ambulatory encounter data, CMRI has proposed a review methodology focused on the primary care physician, the gate-keeper in a capitated system. Until uniform data are available, more innovative methodologies are not feasible.

In summary: PRO review of risk capitation HMOs/CMPs in California, Hawaii and Arizona has gotten off to a well intended but shaky start.

PROBLEMS IDENTIFIED

In the relatively brief period of time that QRO review has been implemented in California, Hawaii and Arizona, there have been some operational and policy issues that have been identified and that need to be addressed. In addition, there will need to be adjustments and fine tuning of the program to enhance some of the program components. Areas of concern include general issues that relate to the program overall, issues specific to the HMO and CMP plans, and issues limited to QRO operations.

GENERAL CONCERNS

The general concerns that impact all portions of the program relate to data, beneficiary education, and definition of parameters for accountability.

1. Incomplete Acute Hospital Data

The first concern that was identified and applies nationwide is incomplete acute hospital data due to the lack of incentive for hospitals providing care to HMO beneficiaries to submit a UB-82 billing form for each inpatient hospitalization. In addition, for those claims that have been submitted, there have been problems among fiscal intermediaries nationwide with consistent identification of those claims that pertain to at-risk beneficiaries. These problems result in a lack of data available to the QRO for data analysis and case selection.

2. Lack of Uniform Data Sets

The second issue relates to the lack of uniform data sets for encounters for beneficiaries receiving care outside of the acute hospital setting, such as ambulatory, skilled nursing or home health care.

3. Beneficiary Education

We have identified the need for further education of the beneficiaries in order for seniors to understand the services available, the alternative delivery system they have selected, limitations of capitated health plans, their rights as HMO beneficiaries, the potential for the Plan to choose not to renew its contract with the federal government and to enhance beneficiary awareness of and access to the QRO.

4. Access to Health Care Services

The final area of general concern relates to the lack of definitions or parameters for assessing whether care is rendered timely and if patients are afforded appropriate access to care. While this is not a clearly identified problem at this time, it is felt that it will become an issue in the future.

CONCERNS RELATED TO PLANS

Difficulties experienced by the plans in the implementation of the program which have created impediments to a plan's ability to fully cooperate with the review program may be related to the choice of model; that is, the IPA model versus the staff model. Most notably is the problem with IPA models not being able to collect all needed patient records from the various encounter sites in which the patient was treated in order for review to take place at one location. The variations in provider and practitioner controls are more evident with the IPA models than the staff models where records are compiled and maintained together and there appears to be little resistance to accessing medical records from the physician office setting.

CONCERNS OF THE QRO

Some of the difficulties that have been encountered by the Quality Review Organization to date include but are not necessarily limited to: (1) the ability of the QRO to meet contract obligations to perform timely review when data and medical records are not available. (2) Variations in program policy interpretation suggests a need for improved coordination among divisions of HCFA when issuing instructions and/or guidelines related to components of the program.

Because the QRO is a new program, pioneering new areas of oversight, it is understandable that there will be a learning curve associated with improving the operations of the program. Variations in timeliness and consistency of information will exist in this program just as there was with the implementation of the PRO program, since the various participants in this program (the QRO, the FIs and the Plans) report to various divisions within the Health Care Financing Administration. Identification of the situation will lead, we trust, to an improved communication network.

SUGGESTIONS FOR IMPROVEMENT OF THE PROGRAM

As a QRO with less than nine months' operational experience, and at this point in time the most experienced nationwide, we would first strongly recommend that the newness and complexity of this program be recognized and that time, HCFA and QRO staff effort, and continued congressional supportbe committed to identify, assess, and find viable solutions to the impediments encountered thus far. It might be to the best advantage of all involved if a national task force was convened and that the participants in this task force include active operational people from Health Care Financing Administration, from Health Maintenance Organizations and Competitive Medical Plans, and from QROs. Their charge would be to address current and future problems identified- and develop standardized solutions that would serve all involved, but most importantly the Medicare beneficiaries of the nation. Versions of this type of operational task force have been utilized in California for several years, including a task force of the California Association of Hospitals and Health Systems/CMRI and a CMRI/FI Task Force. Representatives from HCFA Region IX attend both groups and from everyone's perspective this method has been extremelyeffective in identifying and solving problems.

SECOND:

Since the root of many of the problems identified to date have revolved around data or the lack of it, dollars should be committed for coordination of efforts among the FIs nationwide. Funds should also be dedicated to a one-time investment in an effective, efficient management information system (MIS) for each HMO/CMP committed to providing care to the Medicare population. Funds for development of an MIS could possibly alleviate the frustrations of many of the Plans and avert the decision of some Plans to abandon their HMO at-risk Medicare program.

THIRD:

A Commission should be established to develop a uniform ambulatory data set comparable to the one designed for inpatient acute hospital care. Without a uniform ambulatory data set it will be impossible to aggregate meaningful national data, and QROs' ability to function will be impeded.

FOURTH:

The QROs' and Plans' legal rights to and responsibilities for Medicare beneficiaries' records must be clarified. In addition, beneficiaries must be made more aware that review of their care will be taking place for their protection and that confidentiality will be faithfully guarded. Further, minimum guidelines should be established to assist HMOs/CMPs in their contracting relationships with providers and practitioners, thereby establishing QRO and Plan authority and alleviating distress over the access to records. (See Attachment C.)

FIFTH:

Contracts between HCFA and a Plan should include minimum standards to assure that Plan responsibilities in managed health care and quality review are clearly understood to include but not be limited to: provision of records for review, responsibility for quality of care rendered, mandatory beneficiary education and mandatory educational programs for contract practitioners and providers. In addition an incentive must be designed and integrated into the system to assure accurate data reporting, and that recourse for lack of cooperation, especially in the area of providing records, be clearly stated at the forefront of the program.

SIXTH:

It is also critical that adequate dollars be provided to QROs to assure sufficient staff are available to educate beneficiaries regarding their rights and to not only receive beneficiary inquiries but to appropriately investigate and correct identified problems.

SEVENTH:

To assist QROs in implementing and improving this program, it is important that a communication network be established linking the various divisions of HCFA, the QROs, FIs, and Plans. This may be a staged effort first coordinating the several departments within the government, then linking in the operational components of FIs, QROs, and Plans. We also think it is critical that this program be supported and enhanced rather than abandoned at this early stage of the experience. Further experience and commitment to the suggestions made by CMRI and others providing testimony will make it as effective as the PRO program.

FINALLY:

We would ask a commitment from all involved in this process to be responsive to the experience we have to date and the experience we believe we will obtain in the next contract cycle. This experience may, in fact, lead us to design a less costly but more effective review program. We also need a commitment to the time, people and dollars necessary to assess the experiences unique to various QROs, the aggregate QRO experience, and task force results. Such analysis has the potential to improve PRO as well as QRO review methodologies by eventually relating an improved system in managed health care (Plan accountability for practitioners and providers) to the fee-for-service setting by further involving hospital medical staffs in the accountability for the quality care provided by their members. Most importantly, commitment to support this evolution of professional review will serve to meet the common goal of Congress, HCFA, PROs, QROs, providers and practitioners nationwide--assuring quality health care for Medicare beneficiaries.

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Conditions	ICD-9-CM Codes	Time Period Minimums for Record Review
*1. Diabetic Complications		1. 3 months prior, 3 months post
Diabetes with Ketacidosis	250.10 250.11	
Diabetes with Hyperosmolar coma	250.20 250.21	
Diabetes with other coma	250.30 250.31	
Hypoglycemic coma	251.0	
2. Acute appenditis with gen. peritonitis	540.0	2. 1 month prior
Acute app. with peritoneal abscess	540.1	
3. Hypertensive Problems		3. 6 months prior
Intracerebral hemorrhage	431	
Other and unspec. intracranial hem.	432.0-432.9	
Occlus and stenosis of precereb art	433.0-433.9	
Occlusion of cerebral arteries	434.0-434.9	
Transient cerebral ischemia	435.0-435.9	
Ac, ill-defined, cerebrovas disease	436	
Other ill-defined cerebrovas disease	437.0-437.9	
4. GI Catastrophies		4. 6 months prior
Acute gastric ulcer with hemorrhage without obstruction	531.00	
Chronic or unspecified gastric ulcer with hemorr without obstruction	531.40	
Chronic duodenal ulcer with hemorrhage without obstruction	532.40	
Unspecified intestinal obstruction	560.9	
*5. Gangrene of the Extremity	785.4	5. 6 months prior, 6 months post
6. Operations for Breast Malignancy		6. 1 year prior
Other biopsy of breast	85.12	
Local excision of lesion of breast	85.21	
Resection of quadrant of breast	85.22	
Subtotal mastectomy	85.23	
Unilateral simple mastectomy	85.41	
Bil. simple mastectomy	85.42	
Unil. extended simple mastectomy	85.43	
Bil. extended simple mastectomy	85.44	
Unil. radical mastectomy	85.45	
7. Malignant neoplasm of GU organs		7. 1 year prior
Mal. neoplasm of uterus, part unspec.	179	
Mal neopl of corpus, escept isthmus	182.0	
Mal neopl of isthmus	182.1	
Mal neopl of spec site of body ut	182.8	

Conditions	ICD-9-CM Code	Time Period Minimums for Record Review
*8. Adverse drug reactions		8. 3 months prior, 3 months post
Hemmorrhagic disorder due to circulating anticoagulants	286.5	
Paranoid &/or Halluc. states induced by drugs	292.1	
Pathological drug intoxication	292.2	
Poisoning by primaril sys. agents	963.0-963.9	
Poisoning by anticoagulants	964.2	
Poison. by analgesics, antipyretics, and antirheumatics	965.0-965.9	
Poison. by unspec. sed or hypnotic	967.9	
Poison by parasympathomimetics	971.0	
Poisoning by agents prim. affecting cardiovascular system	972.0-972.9	
Poison by water, mineral and uric acid metabolism drugs	974.0-974.7	
Poison by unspec drug or medicine	977.9	
Unspecified adverse effect of drug, medicinal and biological substance	995.2	
*9. Other cellulitis and abscess	682.0-682.9	9. 3 months prior, 3 months post
10. Malignant neoplasm of colon	153.0-153.9	10. 1 year prior
*11. Hypokalemia	276.8	11. 3 months prior, 3 months post
*12. Septicemia	038.0-038.9	12. 3 months prior, 3 months post
*13. Pulmonary embolus	415.1	13. 3 months prior, 3 months post

ATTACHMENT C

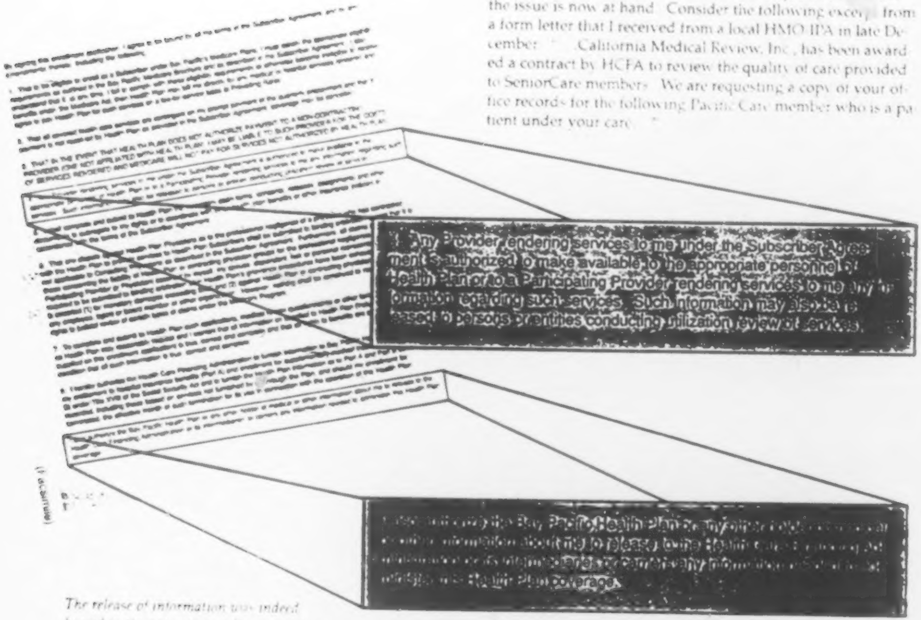
Government access to medical records violates confidentiality

Physician turns down CMRI request after patient balks at disclosure request

By Sidney Marchasin, M.D.

Do peer review organizations (PROs) have the right to randomly examine a patient's entire office chart? Are senior citizens automatically surrendering their rights to confidentiality when they become Medicare patients?

The courts will have to answer these questions because the issue is now at hand. Consider the following excerpt from a form letter that I received from a local HMO/IPA in late December: "... California Medical Review, Inc., has been awarded a contract by HCFA to review the quality of care provided to SeniorCare members. We are requesting a copy of your office records for the following PacifiCare member who is a patient under your care ..."



1. Any Provider rendering services to me under the Subscriber Agreement is authorized to make available to the appropriate personnel of Health Plan or to a Participating Provider rendering services to me any information regarding such services. Such information may also be released to persons or entities conducting utilization review of services.

[illegible] the Bay Pacific Health Plan or any other [illegible] information about me to release to the Health [illegible] charges or carriers any information [illegible] Health Plan coverage.

The release of information was indeed buried in the patient's enrollment application and subscriber agreement.

The dilemma of a mature society is to steer a balanced course between absolute disclosure and absolute secrecy

CMA's legal counsel on PRO law and confidentiality

CP asked CMA's legal counsel Catherine Hanson to comment on Dr. Marchasin's situation. According to Ms. Hanson, the law that the IPA refers to in requesting records review is not yet in effect.

"The legislation authorizing PRO review of physician office charts, the Omnibus Budget Reconciliation Act of 1986, does not require this review before January 1, 1989," Ms. Hanson says. "No regulations have been adopted to provide special protection for the highly confidential information contained in office charts."

A quick phone call to my patient revealed that she was vigorously opposed to having her chart released to a peer assessor. Moreover, she admonished me that she expected me to maintain the privacy of her files.

When I notified the IPA that they needed to provide me with a written release from the patient for the information requested, their response was swift. "Medicare law requires that all Medicare patient records be accessible for review. In addition, your patient signed a release of information form as a condition of enrollment in the Senior-Care program. Please submit the records requested."

A second conversation with my patient revealed that she was unaware of having signed a release of information statement. But the statements were indeed buried in the enrollment application and subscriber agreement form that she had signed.

Does Medicare curb rights?

At issue here is not only a patient's rights to confidentiality, but whether the government has the power to change those rights.

In the past, release of patient information to third parties required proof of need, plus valid written patient consent or a court order. Current government policy contravenes the principle of confidentiality. Congress has, in effect, demanded a security leak as a prerequisite to physicians' conducting their normal business.

The notion that government needs and is therefore entitled to personal information has occurred without sufficient warning to individuals. This policy has been introduced through the back door without discussions between Congress, patients, and the profession as a whole.

The need for confidentiality

Any family physician could explain the necessity of confidentiality to government bureaucrats. In the course of rendering medical care, there are some things best left unrevealed and unsaid. Someone's psychiatric care, someone's sexual problems, someone's emotional problems are private matters that should not be disclosed to government officials who have absolutely no business knowing about them. If the free flow of doctor-patient information is hampered, the quality of medical care will deteriorate, not improve.

A patient who is not assured of confidentiality and privacy will be reticent to disclose sensitive personal information. Patients ought to have the right to talk to their doctors without some government functionary being privy to the details of their conversation.

The physician's code of ethics mandates that information from a patient is kept in confidence and divulged only with the patient's permission. Physicians might also be inhibited from recording their thoughts and opinions to protect their patient's confidentiality.

Clearly, injustice is done to the individual by revealing personal information that is not useful as a measure of quality. There must be safeguards to prevent disclosures that might cause patients harm or distress. After all, the office record is designed to meet the requirements of medical personnel and is not a direct form of communication between the physician and the government.

Government's right to know?

There is another side to this issue. What should the government be entitled to know?

Government participation in Medicare and Medicaid programs involves the taxpayers' money. Some monitoring of medical claims is necessary to prevent fraud and abuse and to evaluate the quality of care. On the other hand, providing the government free license to examine all medical records without patient consent is unconscionable.

Quality medical care is a noble concept, but, in a quiet way, so is privacy. The dilemma of a mature society is to steer a balanced course between absolute disclosure and absolute secrecy. As it stands now, government access is out of balance.

My dilemma has not ended, and the discussion has only begun. At the time of this writing, I have refused to part with my patient's files. Copies of all correspondence have been shared with the editorial departments at numerous California newspapers. I also have communicated with representatives of the American Association of Retired Persons and plan to contact the American Civil Liberties Union.

Already I have received letters of support from various members of my local community—including a rabbi and a priest—urging me to continue my battle.

Where will it all end? Stay tuned.

Dr. Marchasin is a Redwood City internist.

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Chairman STARK. Thank you. Dr. Berwick, help me out here a little, if you can. I have been led to believe that the Harvard Community Health Plan has one of if not the best quality control systems in the whole world. Now, can you tell me briefly, and in language that I can understand, what you do. If I get my mother to move there and quit smoking so she can join your HMO, what do you tell me as the lay person? Do you have meetings, do you check me? Can you give me a kind of run-through—and in particular with emphasis on what you may do which is different from the general practice.

Dr. BERWICK. I'll try to do your question justice, but it's hard to summarize quickly. There are two categories of what we do: one I think is culture and the other is technique. Technique is easiest to talk about. We spend a lot of money at it, first. The budget of my department—and my department is only responsible for measurement, not for fixing anything—that's the management's responsibility—is $1.2 million with a premium income of $400 million. That's about one-third of 1 percent of the premium income.

Chairman STARK. So you are charged with saying there is a problem.

Dr. BERWICK. My job is to measure and to report honestly up and down throughout the organization to everyone within the organization—clinicians, staff, managers, and board. Because they feel and have felt for some time that the cost pressure is so enormous and the financial data so precise that unless the precision of the financial data is matched by something like precise information on quality, attention will go where the data are.

But it costs money, as Dr. Moncrief said, $1.2 million is a hard-money budget that I can rely on this year for the measurement of the care of that population. That's much more than probably any other organization of any size is putting in just in the interest of measurement.

Chairman STARK. $1.2 million out of how much gross revenues?

Dr. BERWICK. Out of about $400 million. It comes to about a third of a percent of gross premium revenues—for measurement; that does not include utilization review and it does not include the managerial acts to improve.

The second investment in data systems—we have a computerized records system, which makes my job much easier—but beyond that we are allowed to set up data systems to support the investigation of quality, and that's where a lot of the resources of my department go.

The third technical component I call a sort of positivist attitude toward measurement, which is we just keep trying measuring things; we'll do all sorts of things. I've visited many other industries and copied measurement techniques from airlines, the hotel industry, products manufacturing.

Chairman STARK. Do you concentrate on me and my pulse and my cholesterol and my weight, and those physical things, or do you concentrate on what the system provides me? You probably do both—but help me there a little bit.

Dr. BERWICK. There are two answers to your question. We concentrate first—the notion is we will go where the trouble is, that the first step of measurement is find out where there are hazards

ATTACHMENT A

BASIS FOR SELECTING RECORDS TO BE REVIEWED	TYPES OF REVIEW TO BE CONDUCTED BY SETTING	LIMITED HCFA REVIEW	BASIC HCFA REVIEW	INTENSIFIED HCFA REVIEW
Thirteen conditions selected on the basis of diagnosis	Inpatient Care: Quality of care (including generic quality screens), timing of care, appropriateness of setting, premature discharge. Pre-Hospital Ambulatory Care: Quality of care, access to care, appropriateness of setting. Post-Hospital Care (all settings): Quality, access to care, appropriateness of setting.	Review a 50 percent random sample of hospitalizations for four of the conditions (hypertensive conditions, two of the asterisked conditions, and one other condition), up to a maximum of 150 cases plus one in eight of every remaining case thereafter; review all pre-hospitalization ambulatory care for the cases selected; review all post-hospital care in any setting for the cases selected in at least two of the asterisked conditions.	Review a 50 percent random sample of hospitalizations for all thirteen conditions, to a maximum of 150 cases plus one in eight of every remaining cases thereafter; review all pre-hospitalization ambulatory care for the cases selected; review all post-hospital care in any setting for the cases selected in at least 7 of the asterisked conditions. At a minimum, review at least 30 cases during the contract, or 100 percent of eligible cases if less than 30 occur.	Review all hospitalizations for the thirteen conditions, up to a maximum of 150 cases plus one in eight of every remaining case thereafter; review all pre-hospitalization ambulatory care for the cases selected; review post-hospital care in any setting for the cases selected in at least seven of the asterisked conditions. At a minimum, review at least 30 cases during the contract, or 100% of eligible cases if less than 30 cases occur.
Random sample of inpatient cases	Inpatient Care: Quality of care (including generic quality screens and discharge review), under-utilization, appropriateness of setting	Review a 3 percent random sample of all hospital inpatient cases.	Review a 5 percent random sample of all hospital inpatient cases. At a minimum, review at at least 30 cases during the contract, or 100 percent of eligible cases if less than 30 occur.	Review a 6 percent random sample of all hospital inpatient cases. At a minimum, review at least 30 cases during the contract, or 100 percent of eligible cases if less than 30 occur.
Non-trauma deaths in all health care settings	Inpatient Care: Quality of care (including generic quality screens), under-utilization, appropriateness of setting, premature discharge. Pre-Hospital Ambulatory Care: Quality of care (under-utilization), access to care, appropriateness of setting. Post-Hospital Care (all settings): Quality (under-utilization), access to care, appropriateness of setting.	Review all hospitalizations, all pre-hospitalization ambulatory care, and all post-hospital care in any setting for a 5 percent random sample of deaths, up to a maximum of 15 deaths plus one in eighty of every remaining death.	Review all hospitalizations, all pre-hospitalization ambulatory care, and all post-hospital care in any setting for a 10 percent random sample of deaths, to a maximum of 30 deaths plus one in forty of every remaining death. At a minimum, review at least 30 cases during the contract, or 100 percent of eligible cases if less than 30 deaths occur.	Review all hospitalizations, all pre-hospitalization ambulatory care, and all post-hospital care in any setting for all deaths.
Focused review of ambulatory care cases	Ambulatory Care: Quality of care, access to care, appropriateness of setting.	Review a focused sample of ambulatory care cases, selected by a method to be developed within 6 months of effective date of contract, up to a maximum of 100 cases plus one-fourth of the sampling level for all remaining cases.	Review a focused sample of ambulatory care cases, selected by a method to be developed within 6 months of effective date of contract, up to a maximum of 100 cases plus one-fourth of the sampling level for all remaining cases. At a minimum, review at least 30 cases during the contract, or 100 percent of eligible cases if less than 30 cases occur.	Review a focused sample of ambulatory care cases, selected by a method to be developed within 6 months of effective date of contract. At a minimum, review at least 30 cases during the contract, or 100 percent of eligible cases if less than 30 cases occur.
Transfers from non-HMO/CMP contracting hospitals to HMO/CMP hospitals	Inpatient Care: Quality of care (including generic quality screens), appropriateness of transfer, including medical stability of patient.	Review all transfers from non-HMO/CMP contracting hospitals to HMO/CMP hospitals.	Review all transfers from non-HMO/CMP contracting hospitals to HMO/CMP hospitals.	Review all transfers from non-HMO/CMP contracting hospitals to HMO/CMP hospitals.

BASIS FOR SELECTING RECORDS TO BE REVIEWED	TYPES OF REVIEW TO BE CONDUCTED BY SETTING	LIMITED UCPA REVIEW	BASIC UCPA REVIEW	INTENSIFIED UCPA REVIEW
Readmissions within 0-7 days of a prior hospital discharge	Inpatient Care: Quality of care (including generic quality screens and discharge review), under-utilization, appropriateness of setting. Post-Hospital Care (all settings): Care between admissions, quality of care, access to care, appropriateness of setting.	Review both the initial and subsequent hospital stay, and all care regardless of setting between the stays, for a 25 percent random sample of these 0-7 day readmissions. Review up to a maximum of 30 cases plus one in sixteen of all remaining readmissions.	Review both the initial and subsequent hospital stay, and all care regardless of setting between the stays, for a 50 percent random sample of these 1-7 day readmissions. Review up to a maximum of 60 cases plus one in eight of all remaining readmissions. At a minimum, review at least 30 cases during the contract, or 100 percent of eligible cases if less than 30 readmission cases occur.	Review both the initial and subsequent hospital stay, and all care regardless of setting between the stays, for all of these 0-7 day readmissions. At a minimum, review at least 30 cases during the contract, or 100 percent of eligible cases if less than 30 readmission cases occur.
Readmissions within 0-15 days of a prior prior hospital discharge	Inpatient Care: Quality of care (including generic quality screens and discharge review), under-utilization, appropriateness of setting. Post-Hospital Care (all settings): Care between admissions, quality of care, access to care, appropriateness of setting.	Review both the initial and subsequent hospital stay, and all care regardless of setting between the stays, for a 25 percent random sample of these 0-15 day readmissions. Review up to a maximum of 30 cases plus one in sixteen of all remaining readmissions.	Review both the initial and subsequent hospital stay, and all care regardless of setting between the stays, for a 50 percent random sample of these 0-15 day readmissions. Review up to a maximum of 60 cases plus one in eight of all remaining readmissions. At a minimum, review at least 30 cases during the contract, or 100 percent of eligible cases if less than 30 readmission cases occur.	Review both the initial and subsequent hospital stay, and all care regardless of setting between the stays, for all of these 0-15 day readmissions. At a minimum, review at least 30 cases during the contract, or 100 percent of eligible cases if less than 30 readmission cases occur.
Readmissions within 16-30 days of a prior hospital discharge	Inpatient Care: Quality of care (including generic quality screens and discharge review), under-utilization, appropriateness of setting. Post-Hospital Care (all settings): Care between admissions, quality of care, access to care, appropriateness of setting.	Review both the initial and subsequent hospital stay, and all care regardless of setting between the stays, for a 25 percent random sample of these 16-30 day readmissions. Review up to a maximum of 15 cases plus one in twenty-seven of all remaining readmissions.	Review both the initial and subsequent hospital stay, and all care regardless of setting between the stays, for a 25 percent random sample of these 16-30 day readmissions. Review up to a maximum of 30 cases plus one in sixteen of all such remaining readmissions. At a minimum, review at least 30 cases during the contract, or 100 percent of eligible cases if less than 30 readmission cases occur.	Review both the initial and subsequent hospital stay, and all care regardless of setting between the stays, for all of these 16-30 day readmissions. At a minimum, review at least 30 cases during the contract, or 100 percent of eligible cases if less than 30 readmission cases occur.

built into the system and concentrate measurement there. But your question also goes to the definition of quality. We define quality with seven different dimensions, seven elements. The measurement program you would observe in my department has programmatic elements oriented toward different components of quality. We do do outcome measurements; we also measure the technical process of care.

Chairman STARK. What are those quality components?

Dr. BERWICK. I'll tell you what they are—you may want to ask more. Outcomes wherever possible. We are focusing currently——

Chairman STARK. Do I live or do I die?

Dr. BERWICK. Well, there are three forms of outcome—living and dying for sure; the social and role functioning of the individual, and symptom levels. Those three areas are all measured with respect to different kinds of disability and disease and different patient populations—it requires a lot more work.

The second area is called technical process patient, and this has a special definition. Dr. Roper earlier spoke of HCFA's growing interest in developing what I call specifications for care. Now, for HCFA that is an issue of surveillance; for a producer, like an HMO, it's an issue of standards internally—how do we wish to take care of low back pain cr heart attacks or depression? Our organization is committed to developing internal specifications, and it then becomes my role to study whether we are adhering to our own specifications. That's quality.

Chairman STARK. In other words, somebody else does the specifications, and you just say, OK. The thoracic surgeon decides about heart surgery along with the internist, and they set the standards; then you just make sure they are following their own rules.

Dr. BERWICK. It's rather more complex. One of the principles of good quality assurance internally in an organization is that the quality measurer should be involved in the design also because measurement can be built into design. But I participate in the standard setting.

Chairman STARK. In standard quality control there is a marginal area which I'm not sure you can tolerate in medical care; in other words, at some level it's too costly to get 100-percent perfection, so you are willing to accept a certain amount of failures or rejections, or whatever, in the interests of lower production cost. Can a physician ethically tolerate that?

Dr. BERWICK. An individual physician ethically tolerate the assumption of additional risk in order to save money?

Chairman STARK. Yes.

Dr. BERWICK. I don't believe an individual physician ethically ought to tolerate that. As an organization, there are facts of existence so that whatever care process standards are to be set have to be set with some notion of intelligent and responsible parsimony. I happen to feel, from research that I know and have done myself, that the risks inherent in the kind of investment in parsimony you are calling our attention to are—they are there, but they really pale in comparison to some of the risks that are inherent in overdoing things. And I think there's tremendous room for improvement of the specifications without the kind of risk you are talking about.

I know of specifications that have been developed in which there have to be tradeoffs made between what would be absurd investments—absurd investments—in additional resources, which would have to come from somewhere else and put someone else at risk.

In general, though, a conscientious specification for good care process is also relatively parsimonious.

The other dimensions of care are access to care, the ability to get into the system when you want to and need to and feel you need to; the interpersonal nature of care—we distribute tens of thousands of surveys to our patients asking them to describe the care they received, and that is an element of quality as far as our organization defines it; integration of care, which is the coordination of care around a large system—if I were HCFA or you, concerned about vulnerability in managed care systems, that's where it is—managed care systems are large and it's very difficult to maintain coherent patterns. We inspect our physical facility and we also measure the attitude and morale of our staff, because it's our belief that we have an obligation to the physicians and people who work for us to create a suitable work environment for them.

Chairman STARK. As you maximize your ability to measure accurately, you must, it seems to me, be able to define very precisely more and more detail of each procedure or each treatment.

Dr. BERWICK. That's a reasonable way to put it, although let me caution against one misconception. The view of measurement held in my organization—and I think a modern view of quality measurement—measurement doesn't drive improvement, measurement is a tool for improvement. And in a way what we measure is derived from the aspirations of the organization: we measure what we care about.

Chairman STARK. What I am getting at is that I have noticed—and I don't think it's just my paranoia—but I've noticed a reluctance in the fee-for-service physician community—for example, I grew up in the days when the AMA wouldn't let Kaiser doctors into the club because they thought they were unethical for working on a salary; at least now they have broadened their view into the 19th century. But I do get a sense that there is a certain element of saying it's none of your business how I practice, it's my craft or my art to me, and don't ask. I rather sense that's one very extreme and small part of the profession, but it's there, and particularly when dollars are at the other end of that question there's even a level of indignation that you would ask.

Your program seems to me to almost be approaching what I've always referred to as the Canadian system, a system where the measurements of what is done are precise and stored and studied. And do you get a resentment—you've been involved with this a long time—from your professional colleagues? It sounds to me like you've got to have one hell of a lot of cooperation or it can't work. I'll stop there and ask you to comment on that.

Dr. BERWICK. I told you that in order to implement the program that we have been able to in our organization, it requires technique and it requires culture. And you are talking about a cultural set. If I were to approach my job as the job of finding people doing something wrong so that they can be disciplined or regulated or correct-ed, I couldn't get the work done. No industry can improve if it fashions the job of improvement as the job of catching people.

Once that myth is put aside, the job becomes a little bit different: it's to work with the professionals in my organization, the physicians and the professional managers, to jointly define what we intend to do, and to do it continuously better. As long as I can keep my eye on that goal, physicians like any people who care about their work are willing to work to try to make things better. When we slip over to an accusatory mode, we lose.

I must say that the ambient environment, the external environment, is so constantly surveilled and disciplinary that it's very difficult for people to believe that the enterprise of measurement and improvement can be undertaken with acceptably low levels of personal risk and with a kind of positive view of what's possible. I don't know if that answers the question.

Chairman STARK. Let me just finish on that line. Your state is in the forefront of legislation concerning medical care. Mr. Donnelly is unfortunately not here to praise Massachusetts' mandatory assignment laws. Do you think you could—let's just say for the Massachusetts legislature, so you are in a climate where there is a tendency to have a high degree of social conscience—write a law that would put your program into effect in the State of Massachusetts? Admittedly there would be some limitations, but could you craft legislative language that would enforce your standards on your State's medical delivery system?

Now, that has to assume some things—but that's hypothetical. I've always said it's very hard to write a law that says you've got to give tender loving care—I don't know how you do that in legislative language and oversee it. But could you with your approach?

Dr. BERWICK. I believe I could, but it would not be free. The law I would write—I've never quite thought of writing a law before—but the law I would write would be something that supports the installation of developmental techniques for the industry, makes it in the industry's interest to do that—and, like any developmental effort, it will require that the return on investment is downstream, not now.

The discount rate in our industry for investments of that sort at the moment is so high that I think the amount—I think it might be frightening.

Chairman STARK. You have touched on something—I don't mean to get back to ophthalmologists, but it's a perfect example of where in the Medicare system we are not getting the benefits of increased productivity. What happens here is that a procedure drops from a 2-hour procedure to a 10-minute procedure, and I'm still paying the fee for two hours, which is good for awhile to recapture the investment in research and so forth, but at some point I ought to get some of that savings.

Dr. BERWICK. We are getting in the Medicare system what you'd expect you would get from an industry when you say we are watching, and we are going to catch you if you screw up. That's what we are getting—not better care, not general improvements in efficiency and quality; we are occasionally finding people who are screwing up and doing something to them. That is probably necessary public policy at some level from the point of view of your oversight responsibility, but don't expect it to improve things, because it won't.

Chairman Stark. Bill, what can we do in California?

Dr. Moncrief. I'd just like to emphasize what Don has just said. I think he made a very important statement. In Harvard Community Health he said: we measure what we care about. And I think this is what has to be developed. There are physicians in Harvard Community Health that care about Harvard community health. In California the bulk of the care in this segment that we are looking at today is in the IPA model, and that individual practitioner has absolutely no loyalty to FHP or to maxicare or to anything like that; he's just cranking out a product.

Chairman Stark. Does he get paid per procedure or per hour?

Dr. Moncrief. And until you can identify and engender that concept of "we measure what we care about," the program is going to continually be in trouble.

Chairman Stark. Now, help me, because I always suspect that an interest in quality is only exceeded by an interest in dollars—and we don't understand quality here because we can't spell most of the procedures we are supposed to ask for high quality in. But we do understand dollars—we probably waste more than any other organization in the world.

Can you define for us a set of rules so—and I'm not suggesting that I can make people have warm hands before they push my tummy—so that we can find ways to put a financial incentive on this person to do preventive care, even though they are not going to get paid? What financial interest does my heart surgeon have in getting my cholesterol down? And I'm not even suggesting they would have another incentive—to get me to eat steak and sour cream and cheese so that I would get to him quicker and he could get a patient.

Now, can we write laws where the only thing we have to play with are the dollars, where we can turn that financial incentive around? And would that help you in California and/or Massachusetts?

Dr. Moncrief. Well, one of the problems with the Medicare program is that you are not reimbursed for preventive medicine; you are reimbursed for therapeutic medicine. So the incentive for preventive medicine is minimum in the general environment. In the HMO, in the risk capitation environment, there is increased incentive to practice preventive medicine, but, as I said earlier, the program is attracting the resource-intensive Medicare beneficiary. So that makes it difficult. It's the elderly beneficiary who has multisystem disease—at least that's been the experience in California. And I think that was recognized in setting up the legislation when they said you can have only one risk Medicare beneficiary for every two nonrisk Medicare beneficiaries enrolled in your program, because they recognized this incentive to get into the program.

We are trying to do what Don has emphasized, education and improving performance by accumulating data on performance. But it's awfully difficult in this environment at this stage in the game. It is improving. But I don't think there is any quality review organization—and certainly no PRO—whose principal objective is to close down hospitals or get practitioners out of practice. What we want to see is an appropriate quality of medicine delivered at an appropriate level and utilizing appropriate resources.

Chairman STARK. Let me follow up now, to get a sense of the cultural climate. There are other societies who think somewhat differently from us: Canada has a reimbursement system that's different, and England—they are probably the two most often cited. Can either of you draw any conclusions as to quality—understanding that there are a whole host of differences in the population—and how it's judged under different broad reimbursement systems? In other words, in England, and in Hong Kong, I suppose virtually every one is in a capitation program. In Canada there is a very precise reimbursement system.

Can you make any judgments as to what the cultural incentive is there for quality? Is it different from here?

Dr. BERWICK. I can't answer as deeply as I'd like to, Mr. Chairman. I think one thing is clear to me about the Canadian system, and it relates to the notion that quality cannot be improved before it's defined, it can't be worked on until we know what it is—and it doesn't have to be solved with one elegant sentence—but the Canadians have committed to access. It appears to me that in the Canadian reimbursement context there is the implementation of a notion—and the notion is that all Canadians shall have access to care, it's a right. It's not the case in this country yet. And with respect to the quality, to that dimension of quality, I can find direct relationship between the financial incentives that have been set up and the implementation of a vision of quality. I'm not sure if you want the Canadian system here.

I have one short story. I just got back from Japan. I've been looking at their health care system, which is in bad trouble and of low quality. And I noticed something there that gives me optimism here—whether it's a financial issue or not, I don't know—but Japan lacks an institutional infrastructure for improvement. The hospital in Japan, for example, is not a strong entity; it's a small proprietary entity. I am optimistic because we really do have in this country, unlike in that country, a chance to improve because of a strong collection of institutions that could, with the right setup, the right culture, be made very interested in improvement.

Chairman STARK. So what you are really saying is that the hospitals here have an institutional tradition, regardless of the physicians, and that doesn't exist in Japan?

Dr. BERWICK. Yes, they have a life of their own, they have values; our hospitals tend to have been started in philanthropic modes or community service modes—that's changing a little. You earlier said, somewhat lightheartedly, that quality is important and money is important, but money may be more important. That deserves a little pause and reflection, because if you really believe—really believe—that the average American hospital or the average American physician looks first to finance before he makes his decision, that may be starting on the wrong foot.

Chairman STARK. No, I'm not sure I believe that; but I do think you can quantify that level at which those curves cross.

Dr. BERWICK. Yes, I agree with you, and that is clearly where you can act.

Chairman STARK. We have to go and vote now on supporting the president of Panama, on the assumption he's still alive—and then we are not sure we know where to send the resolution if its passed.

I want to thank you both for your testimony, I appreciate it, and it's been informative. We will recess for about 8 minutes and then reconvene with our final witness.

Thank you very much.

[Brief recess.]

Chairman STARK. Our final witness is Christy W. Bell, the executive director of the Fallon Community Health Plan of Worcester, MA, on behalf of the Group Health Association of America. If you'd like to introduce your colleagues, Mr. Bell, and then proceed in any manner you choose. Welcome to the committee.

STATEMENT OF CHRISTY W. BELL, EXECUTIVE DIRECTOR, FALLON COMMUNITY HEALTH PLAN, WORCESTER, MASS., ON BEHALF OF GROUP HEALTH ASSOCIATION OF AMERICA, INC., [GHAA], ACCOMPANIED BY JAMES F. DOHERTY, PRESIDENT, GHAA, AND JOSEPH A. PODBIELSKI, M.D., PRESIDENT, FALLON CLINIC, INC., WORCESTER, MASS.

Mr. BELL. Thank you very much, Mr. Chairman. To my left is Jim Doherty, the president of the Group Health Association of America, and to my right is Dr. Joseph Podbielski, the president of the Fallon Clinic, a 130-physician multispecialty group practice which provides medical care to our members.

Let me start by saying that we would be very pleased to have your mother enroll in the Fallon health plan; we can enroll her in a nonsmoking program. We do not screen; we take them as they come.

Mr. Chairman, I am the executive director of the Fallon Community Health Plan in Worcester, and I am here representing both the Group Health Association of America, GHAA, and the Plan. GHAA is the national trade association of HMO's, CMP's, and other prepaid health care systems. Our member plans serve approximately 70 percent of the Nation's more than 30 million HMO enrollees.

The Fallon Community Health Plan has an enrollment of 85,000 members, 14,000 of whom are Medicare beneficiaries enrolled in our senior plan. We were the first risk demonstration, and in 1985 became the first TEFRA risk contract.

GHAA strongly supports the concept of providing comprehensive health care to Medicare beneficiaries on a prepaid capitated basis and has been actively involved in proposing and developing such a system. Our purpose was to create a system whereby we could offer benefits and services to the Medicare population in the same way as we provide them to the under-65 enrollees.

The program does hold great potential for all parties involved: the Government saves 5 percent of its usual Medicare costs, the HMO's can increase enrollment, and, most importantly, enrollees receive additional benefits, often at reduced costs by virtue of HMO efficiencies and care management.

Enrollment in Medicare risk contracts will soon exceed one million people. The substantial enrollment reflects the advantages of the program to Medicare beneficiaries.

HMO's and CMP's offer the elderly the opportunity to receive high-quality service in a managed care setting. They receive additional benefits, such as prescription drugs, eyeglasses, and preventive services at affordable premiums. They are spared the inconvenience of dealing with claim forms and other paper work, and for these reasons we have noted a high degree of satisfaction and low disenrollment among those who joined the risk contracts. However, there are a number of major issues that must be addressed in order for the program to continue to grow and attract more contractors and enrollees.

The first issue is the unstable nature of government as a contractor. In a December 1986 survey of GHAA member plans, the two most commonly cited problems by Medicare risk contractors were the unpredictability of AAPCC rates and the threats of midcontract payment cuts. Plans operate on fixed budgets and enter into contracts with the Government and providers, and most important, of course, with enrollees for their needed care. HMO's must rely on financing which is stable over time, and it is essential that plans have reliable revenue to fulfill their multiple contractual commitments.

Of greatest concern is the fluctuations and reductions of the AAPCC rate, which ultimately affect the beneficiaries, because supplemental benefits may be reduced or eliminated, and the premiums may have to be increased.

The 1985 and 1987 Gramm-Rudman reductions were a prime example of the Government's unreliability as a contractor. Although the 1987 cut has been restored, we need assurance that such cuts would not occur again in midcontract.

The fairness of the actual rates paid is the second concern. In our survey of member plans, two-thirds of those with risk contracts cited low rates as a problem, and two-fifths indicated that the Medicare population's higher demands for service were an issue for the plan. Generally, the utilization experience of Medicare risk contractors has been greater than anticipated. This has been found to be especially true in the first year of enrollment, a phenomenon known as unmet need. Medicare beneficiaries may not have recently received appropriate health care and they have to play catchup when they join the HMO or CMP. And a classic example of this, we believe, would be our Medicare heart-transplant recipient who now 1 year post-transplant is doing very well.

At Fallon we have noted a direct correlation between increased Medicare enrollment and increased hospital days per thousand members per year, in spite of the fact that we are using the same medical group and the same utilization controls from year to year.

The implementation of a better way of adjusting for health status in establishing HMO rates needs to be a top priority. If the AAPCC is refined to more adequately account for the health status, the possibility of plans having windfall gains and losses, based solely on the health status of those who join rather than care effectiveness will be diminished.

The third issue with respect to the Medicare risk program's rate method is the need to better define the geographical basis of payment. HMO's are paid at widely ranging rates for beneficiaries residing within a single health care market because the HMO is paid the AAPCC rate for the county in which an enrollee resides not where he or she receives services.

We know that HCFA is aware of these problems and is funding research to examine alternatives.

Fourth, GHAA recommends that consideration be given to separating the payment formula from the fee-for-service experience. We are already beginning to see the effect on rates in areas of high HMO penetration. For example, 6 of the smallest 10 increases in the 1988 part B AAPCC are concentrated in Minnesota, which has a very high HMO penetration. The low increases in physician services may be evidence of a halo effect of managed care modifying the fee-for-service practice patterns.

GHAA is also concerned about the rigid application of the 50/50 rule. Because of HCFA's current refusal to grant waivers to the rule, Congress has intervened in at least three cases. HCFA unwisely and, in our judgment, improperly granted waivers in south Florida and was subsequently burned because of the ensuing scandals.

Perhaps TEFRA should be amended to permit multistate HMO's to qualify for additional flexibility by demonstrating successful commercial and Medicare operations, fiscal soundness, and an ability to meet or exceed PRO review criteria on an ongoing basis.

We would now like to turn our attention to the issue of quality of care in the HMO's. As an industry we are proud, but not complacent, of our achievement and record to date on quality. Research has demonstrated again and again that the quality of care delivered in HMO's is as good or better than the quality of care delivered in the fee-for-service system.

We look forward to the day when the scope of the PRO review program is expanded to include all Medicare Part B services, not just those provided by HMO's. All Medicare beneficiaries should be assured the same high-quality service no matter what the treatment setting. This is particularly crucial as more and more services are provided in the ambulatory setting.

We have serious concerns that HMO's not be measured against strictly fee-for-service standards, because of the obvious difficulties comparing managed to unmanaged care.

Mr. Chairman, as I have pointed out, TEFRA risk contracts are not without problems. Legislation governing risk contracts should be continuously monitored and amended and approved where justified. Hearings such as this make a meaningful contribution toward that end.

We appreciate the opportunity to testify. Thank you very much. And I'd be pleased to answer any questions you might have.

[The statement of Mr. Bell follows:]

STATEMENT OF CHRISTY W. BELL, EXECUTIVE DIRECTOR, FALLON COMMUNITY HEALTH PLAN, WORCESTER, MASS.

Good morning, Mr. Chairman and members of the Subcommittee. My name is Christy W. Bell. I am Executive Director of Fallon Community Health Plan (FCHP) in Worcester, Massachusetts, and I am here today representing Group Health Association of America (GHAA). GHAA is the national trade association of HMOs, CMPs and other prepaid health care systems. Our member plans serve approximately 70 percent of the nation's more than 30 million HMO enrollees.

Fallon Community Health Plan has an enrollment of 85,000 members, 14,000 of whom are Medicare beneficiaries enrolled in our Senior Plan. In 1980, Senior Plan was established as the first demonstration of the proposed Medicare risk contract system. In April 1985, we were the first of 27 demonstration projects to convert to a Medicare risk contract. Our initial enrollment target was to enroll 15 percent of our membership in Senior Plan. We achieved this goal and now enroll over 20 percent of the entire Medicare population of Worcester County.

Our Senior Plan has been successful over the past eight years. We have exceptionally low disenrollment due to dissatisfaction - our surveys show a rate of less than one percent. Our quality is high and the Massachusetts PRO has designated us for limited review, which is the lowest level of PRO/QRO quality review of HMOs under risk contracts. While we remain strongly committed to our members, we share a number of concerns with the industry.

GHAA strongly supports the concept of providing comprehensive health care to Medicare beneficaries on a prepaid capitated basis and has been actively involved in proposing and developing such a system since the creation of Medicare in 1965. Our purpose was to create a system whereby we could offer benefits and services to the Medicare population in the same way as we provide them to the under-65 enrollees. With the enactment of TEFRA 17 years later, the current Medicare risk contracting system was finally put into law. The regulations implementing the program were published in January 1985.

The program holds great potential for all parties involved: the government saves five percent of its usual Medicare costs, the HMOs can maximize market opportunity through increased enrollment, and, most importantly, the enrollees receive additional benefits often at reduced costs by virtue of HMO cost efficiencies and care management.

However, the program has suffered from some significant problems. As you are well aware, Mr. Chairman, serious abuses have occurred in south Florida which have had major, and, in our view, misguided repercussions for the entire HMO industry. We are appalled by such cases which resulted from poor judgment and sloppy oversight by previous HHS officials.

Now we are confident that the vast majority of risk contractors are providing high quality care and operate well within the requirements of the program. We are encouraged that recent actions by HCFA have demonstrated their ability to deal with these problem HMOs.

For the 1988 contract year, 29 risk contractors with a small percentage of the total enrollment, did not renew and several more reduced their service areas. While there are a variety of reasons and circumstances surrounding the withdrawals, the issues they raise present a cause for concern about the viability of the program. On the other hand, it is encouraging that 55 new applications are now pending, and enrollment will soon exceed one million.

The substantial enrollment reflects the advantages of the program to Medicare beneficiaries. HMO/CMPs offer the elderly the opportunity to receive high quality service in a managed care setting. They receive additional benefits such as prescription drugs, eyeglasses and preventive services at affordable premiums. They are spared the inconvenience of dealing with claim forms and other paper work. For these reasons, we have noted a high degree of satisfaction and low disenrollment rates among those who have enrolled in risk contracts.

However, there are a number of major issues that must be addressed in order for the program to continue to grow and attract more contractors and enrollees.

The first issue is the unstable nature of government as a contractor. In a December 1986 survey of GHAA member plans, the two most commonly cited problems by Medicare risk contractors were the unpredictability of AAPCC rates (83 percent of plans with risk contracts) and the threats of mid-contract payment cuts (79 percent of plans with risk contracts). When plans decide whether to enter the Medicare risk contracting program and, if so, how large a commitment to make toward the program in terms of enrollment, they must budget for the services they have to deliver to their enrollees. Plans operate on budgets from which they derive their rates and enter into contracts with the government, providers and, most important, enrollees for needed care. HMOs must rely on financing which is stable over time, and it is essential that plans have reliable revenue to fulfill their multiple contractual commitments. Of greatest concern is that fluctuations and reductions of the AAPCC rate ultimately affect the beneficiaries because supplemental benefits may be reduced or eliminated and premiums may have to be increased.

Sharp differences of annual AAPCC increases, such as have occurred over the past several years, have impeded the ability of HMOs to sensibly plan, develop and implement their senior programs. If plans are to be encouraged to enter the TEFRA program and remain with it, they must be given better information on the basis by which the rates will be calculated, including the nature of any assumptions which are made. They must be assured that the government will be a reliable business partner.

The 1985 and 1987 Gramm-Rudman reductions were a prime example of the government's unreliability as a contractor. These mid-contract cuts disrupted our programs' financial underpinnings and caused consternation among the elderly. Our flexibility to adjust to these unpredicted cuts is very limited. Although the 1987 cut has been restored, we need assurance that such cuts would not occur again in mid-contract.

The fairness of the actual rates paid is the second concern. In our survey of member plans, two-thirds (62 percent) of those with risk contracts cited low area rates as a problem and two-fifths (43 percent) indicated that the Medicare population's higher demands for service were an issue for the plan. Generally, the utilization experience of Medicare risk contractors has been greater than anticipated. This has been found to be especially true in the first year of enrollment, a phenomenon known as unmet need. Medicare beneficiaries may not have recently received appropriate health care and they have to play "catch up" when they join the HMO/CMP. For inpatient services, one half of responding Medicare risk contractors reported experiencing higher utilization of inpatient services than anticipated (one fourth said it was the same and one fourth said it was less); three quarters of plans reported ambulatory utilization at a level greater than anticipated. While undoubtedly some of this represents the short term responses of HMOs adjusting to a new population group with special needs (45 percent of risk contractors surveyed added physicians, 37 percent added new benefits and 14 percent made facility changes), this experience also points up some particular issues which policy-makers should be addressing.

At Fallon we have noted a direct correlation between increased Medicare enrollment and increased hospital days per thousand, using the same medical group, the same doctors and the same utilization controls. For example, in 1982 with 900 new enrollees, we had 1,877 hospital days per thousand; in 1984 with 2,914 new enrollees, we had 2,214 days; in 1985 with 1,119 new enrollees, hospital days dropped to 1,960; and in 1986 with 3,089 new Medicare members, hospital days went back up to 2,076 per thousand.

The implementation of a better way of adjusting for health status in establishing HMO rates needs to be a top priority. Five percent of Medicare beneficiaries account for about 50 percent of the expenditures. With the average Medicare expenditure per beneficiary totalling $2700 per year, plans clearly face a risk in enrolling Medicare beneficiaries. While there was some improvement in predicting group expenditures, the AAPCC has serious weaknesses. If the AAPCC is refined to more adequately account for health status, the possibility of plans having windfall gains and losses, based solely on the health status of those who join rather than economic efficiency, will be diminished.

We have been encouraged by at least one prior hospital use model, which is the Diagnostic Cost Grouping (DCG) methodology of Dr. Arlene Ash and her colleagues from Boston University and Brandeis University. GHAA has been cooperating with the Health Care Financing Administration in the develop- ment of a multi-site demonstration to test out this new model of payment.

The third issue with respect to the Medicare risk contracting program's rate method is the need to better define the geographical basis of payment. HMOs presently are paid widely ranging rates for beneficiaries residing within a single health care market because the HMO is paid the AAPCC rate for the county in which an enrollee resides, not where he or she receives care. Rates in adjacent counties may vary as much as $80 per month even though the cost of providing care is the same.

Setting rates based on over 3,000 separate county areas fails to reflect the actual market situation faced by HMOs and the economic factors and practices driving their costs. The development of more appropriate geographical units for payment would enhance considerably the equity in the program and make HMOs more accessible to a broader number of Medicare beneficiaries. We know that HCFA is aware of these problems and is funding research to examine alternatives.

GHAA recommends that consideration be given to separating the payment formula from the fee-for- service experience. As more Medicare beneficiaries enroll in risk contracts, the pool of fee-for- service beneficiaries will shrink and random fluctuations in Medical payments will be observed not only for the county-level AAPCC, but in the national level USPCC as well. We are already beginning to see the effect on the rates in areas of high HMO penetration. For example, the smallest 10 increases in the 1988 Part B AAPCC are concentrated in Minnesota. Six counties are located around Minneapolis-St. Paul and St. Cloud, and two counties are located in the Portland, Oregon area. Both areas have very high HMO penetration in the health care market, and the low increases in physician services may be evidence of a "halo" effect of managed care modifying the fee-for-service practice patterns.

GHAA is also concerned about the rigid application of the 50/50 rule. Because of HCFA's current refusal to grant waivers to the rule, Congress has intervened in at least three cases. HCFA unwisely and, in our judgment, inproperly granted waivers in south Florida and was subsequently burned because of the ensuing scandals.

Waivers were designed to facilitate enrollment in qualified HMOs serving the elderly. This is still a legitimate and desirable objective. Just as inner city HMOs need Medicaid waivers, so do HMOs in areas where there is a large elderly population. It is ironic that it is in these areas where the AAPCC (ergo, health care costs) is the highest and the need for cost effective systems is greatest.

The true test of an HMO/CMP is the quality of care it provides. Quality coupled with financial viability is the true protection against a proliferation of Medicare mills.

Perhaps TEFRA should be amended to permit multi-state HMOs, as long as they are meeting or exceeding the PRO review criteria, to adjust their local or regional enrollment mix. In order to qualify for additional flexibility, an entity could also be required to meet a higher standard. For example, it could be required to show several years of successful commercial and Medicare operational success as well as a demonstrated track record of financial soundness.

We would now like to turn our attention to the issue of quality of care in HMOs. As an industry, we are proud of our record on quality. Research has demonstrated again and again that the quality of care delivered in HMOs is as good or better than the quality of care delivered in the fee-for-service system. For example, The Fallon Clinic is assuming a leadership role in demonstrating that short length of hospital stay in a variety of surgical procedures performed by Fallon Clinic surgeons on both fee-for-service and pre-paid patients are, in fact, associated with excellent outcomes. In a series of 109 high risk patients who underwent repair of nonruptured abdominal aortic aneurysms an operative mortality of 1.8 percent was seen. This is comparable to the best results published in the country.

The HMO industry's systems of quality assurance have no parallel in fee-for-service medicine, but our faith in our internal systems of quality assurance does not prevent us from recognizing the need for external oversight of quality. Today's atmosphere of greater accountability and public concerns about cost containment have made us realize that we must meet the challenge of demonstrating the high quality of our services not only to ourselves but to the public and to policy makers as well.

As an industry we have been working with the National Committee for Quality Assurance to establish external systems for assuring quality. We also have cooperated with the Health Care Financing Administration (HCFA) and the peer review organizations on the implementation of PRO review of HMOs. We have assisted in the establishment of a PRO-HMO Task Force to aid in the development of quality review methodologies.

We look forward to the day when the scope of the review program is expanded to include all Medicare Part B services, not just those provided by HMOs. All Medicare beneficiaries should be assured the same high quality service no matter what the treatment setting. This is particularly crucial as more and more services are provided in an ambulatory setting.

The effort to address quality, both in HMOs and on the fee-for-service side, will require work. As this is done, we have serious concerns that HMOs not be measured against a fee-for-service standard, since a considerable amount of research suggests weakneses in that system, particularly in terms of potentially unnecessary or less cost-effective care than desirable. Developing appropriate medical care standards will not be an easy task, but it is possible and essential.

Mr. Chairman, as I have pointed out, TEFRA risk contracts are not without problems. However, they do point the way for solutions to spiraling Medicare budgets and ever-increasing out-of-pocket costs to beneficiaries. Benefits are aggregated and paid on a single price basis which is logically the most cost effective way of delivering health care in an age of high inflation and exploding technology. Legislation governing risk contracts should be continuously monitored and amended and improved where justified. Hearings such as this make a meaningful contribution toward that end.

Thank you very much. I am happy to answer any questions.

Chairman **Stark**. Let's go back to your Fallon Community Health Plan for a moment. How big is Worcester now?

Mr. **Bell**. The immediate service area is about 360,000 people.

Chairman **Stark**. Is that your AAPCC? Is that a county as well?

Mr. **Bell**. Worcester County?

Chairman **Stark**. The 360,000, is that the area that the AAPCC is based on?

Mr. **Bell**. No, the AAPCC is based on about 700,000 people in Worcester County.

Chairman **Stark**. But in your trade area there are 360,000 people, and you've got about 20 or 25 percent of the population in your plan.

Mr. **Bell**. In the immediate environment, yes; as you reach further out——

Chairman **Stark**. When did your plan start?

Mr. **Bell**. The health plan, again, in 1977, and Medicare risk contracting began in 1980.

Chairman **Stark**. Was it a group of doctors in group practice, or was it a hospital? What was the catalyst?

Mr. **Bell**. The Fallon Plan was sponsored by the Fallon Clinic, which has been in the Worcester community for now almost 60 years.

Chairman **Stark**. A not-for-profit clinic?

Mr. **Bell**. For-profit, professional corporation, the clinic; the health plan is not-for-profit.

Chairman **Stark**. You heard some discussion today from California and from your colleagues in Massachusetts on the issue of quality, and on the question of how we are going to save money. I would also like to add that you mentioned in your testimony the aberrations that have grown in your society, your HMO group.

What would you think about the idea of insisting that these captive plans be nonprofit?

Mr. **Bell**. I don't think the GHAA has a position on that. I think we have very effective——

Chairman **Stark**. How many of your members would you guess are organized for profit and how many are organized for nonprofit?

Mr. **Doherty**. That's hard to say, Congressman, as there are about 200 plans in GHAA, and, of course, Kaiser is a substantial part of the enrollment, even though it comes in as six plans. But we have Prudential, Connecticut General, INA, or Cigna. I would say that of the total enrollment covered by GHAA—and this is a guess, and I will get you the accurate figure—that around 30 or 40 percent are represented in for-profit plans.

[The following was subsequently received:]

GHAA

Group Health Association
of America, Inc.

1129 Twentieth Street, NW
Suite 600
Washington, DC 20036
202/778-3200

Representing
Organized, Prepaid
Health Care Systems

Officers

Chairman of the Board
[illegible]

Past Chairman
[illegible]

Chairman Elect
[illegible]

Directors
[illegible]

President and Chief Executive Officer
[illegible]

March 28, 1988

The Honorable Pete Stark
Chairman, Health Subcommittee
House Ways and Means Committee
1114 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Stark:

This is in response to your question at the Medicare Capitation hearing on March 10, of how many GHAA member plans are for-profit and non-profit.

Our latest information is as follows:

For-profit: 98 plans
Total enrollment: 4,615,401

Non-profit: 102 plans
Total enrollment: 10,863,747

Therefore, while the number of for-profit and non-profit plans is about equal, almost two and one-half times as many individuals are enrolled in non-profit organizations.

Please contact me if we can provide further information.

Sincerely,

James F. Doherty

James F. Doherty
President

Chairman **Stark**. Now, would you include people like Prudential and Cigna in that?

Mr. **Doherty**. Yes. Prudential is not a stock company, it's a mutual company, but we include the Prudential membership——

Chairman **Stark**. I say that not in a contentious sense—but in the theory that if you take the previous witnesses' ideas or suggestions that if the sole concern of the enterprise is to improve the quality of life then you at least eliminate that incentive which might translate into adverse selection and lack of care. In other words, the only way that I can see that you can make a little extra profit is by being a little extra careful in your admissions screenings and being a little tougher on utilization.

Mr. **Doherty**. Yes, but I think that incentive is there regardless of whether or not the plan is profit or non-profit.

Chairman **Stark**. I think it is, too, but the thing is that anybody—seriously, and I believe this is still true, even though I didn't ask Bill Roper about it with an IBM PC Junior and a little bit of chutzpa and a few thousand dollars could go out and become an HMO. It doesn't take much to qualify. You've got to con 10,000 people, but once you do that you'll have the cash flow. And you can contract out everything. You don't have to be a doctor, you don't have to have a hospital, you just have to convince somebody that you are going to subcontract all this out. And so you could conjure up an HMO—not only could I, but I am just following the role models of some of these guys in Florida and southern California. Take a look at the jets and the hotel rooms for mistresses in Europe and all of those things that somehow found their way into the cost reimbursement of an HMO. You would take some of that out if you took out the profit incentive, wouldn't you?

Mr. **Doherty**. Well, you take some of the profit incentive out. Look, Congressman, there is an inherent piece of logic which says that where you have prepayment and where you have risk, there's going to be an incentive, a logical incentive, to under-treat so you can make more money. I don't think that profit or for-profit has anything to do with it. Our question on this whole thing is that the system has worked, some of the finest plans in the country are for-profit, just as some of the finest plans in the country are nonprofit.

But the problem is what are you looking at in terms of the total environment of the plan, and that's what I thought your hearings were about today.

Chairman **Stark**. Well, they are.

Mr. **Doherty**. And you had some excellent testimony on quality measures and that kind of thing that goes hand in hand.

We object to the use of this term "gatekeeper." I don't think that that's appropriate; I don't think the plans I represent consider themselves as having the "gatekeeper" principle. What they do is, people are sick or injured and come to them, and they are appropriately referred and treated.

Chairman **Stark**. That's like you are trying to tell me that dumping doesn't occur in this country at emergency rooms. I would like to think that's true, but I quit believing in the tooth fairy or the Medicare fairy some years ago. I am willing to suggest that every HMO has the best of intentions, their trade associations and their professional associations. Whatever you want to call the primary care person, or committee, but there is indeed—and if you'd like testimony from the psychologists and the rest who are saying—they say they aren't getting any business. And so they think of it as a gatekeeper. You may think of it as a primary care physician. It's part of the problems that we have here as non-professionals—"gatekeeper" isn't such a bad connotation, is it? What do you call it?

Mr. DOHERTY. Primary care practitioners, or you can call it triaging, you can call it anything you want. But people are referred to——

Chairman STARK. The word "Triage" to me sounds a whole lot worse than "gatekeeper."

Mr. DOHERTY. But it's a determination as to what's the appropriate care by a primary care practitioner, so I think your——

Chairman STARK. All I have ever said to that is that there is no way that you can ever tie reimbursement to the decisions made by that primary care person. If that person has any direct compensation based on decisions that he or she has made, then I think that is wrong. Would you agree with that?

Mr. DOHERTY. Yes, but the implication of the term "gatekeeper," as it shows up in the health care literature now, is that somehow or another there should be this——

Chairman STARK. That isn't our fault. There aren't any of us on this committee competent enough to write anything that would qualify as health care literature—laws maybe, but not literature. And so we will have to address that issue to the Ph.D.'s of the world who teach this subject in our great universities.

I'd be happy to have a different term. And I would certainly want the record to show that it's never entered my mind as a pejorative term, or as anything that causes me concern. It's a convenient definition, and I'm sorry if it——

Mr. DOHERTY. You know, the other thing that does bother us is the one that you raised earlier, and that's this business of profit versus nonprofit being the determinant of whether or not these are good systems. The early systems in California, which were the subject of so much scandal, were all nonprofit; the organizations in Florida were nonprofit, or at least the IMC——

Chairman STARK. Was IMC nonprofit?

Mr. DOHERTY. No, I'm wrong on that. But the idea was that in California, with the old PHP scandals, these were nonprofit organizations—prepaid health plans.

Chairman STARK. No, I'm thinking of the guy who ate a Greek, Paracelsus or Paraclesus, one or the other.

Mr. DOHERTY. Oh, no, God forbid that.

Chairman STARK. But that was a profit system, right? What is it—Paracelsus. Paracelsus was a profit operation, right?

Mr. DOHERTY. I don't know. That was a hospital that somehow or another had some kind of a fee-splitting arranging with its DRG. I agree with you about that and your anger about that.

Chairman STARK. I am informed that they were just a chain of hospitals.

Mr. DOHERTY. They were pretty bad.

Chairman STARK. They were very creative.

Mr. **Doherty**. Well, in the early seventies, when this whole idea of the health maintenance strategy was developed, one of the pieces of that strategy was to attract insurance companies and other payors into this alternative delivery system, as a prepaid organized kind of system that we call HMO's.

Chairman **Stark**. I would beg to differ with you; I think it was formed by Kaiser and the Bechtel family under the guise of being eleemosynary. Those two old skinflints did it just to chintz on their employees and cut down on their medical costs during World War II. It predates. Now, out of it, fortunately, has grown—the robber barons also gave us great institutions in California—a great system which is scrupulously honest and provides good care. But the real incentives that started it were a way to save money and beat the insurance companies at their own game when the flood of people coming into California during World War II put Henry J. Kaiser and the Bechtels in that position. The results are wonderful.

But how we all got where we are is a matter of indifference. The real question is how do we save money for the taxpayers? How do we lock in and measure quality—and I am sure you heard enough discussion about that today; I doubt if there is any uniformity or unanimity among your members as to how they measure quality.

Mr. **Doherty**. That's correct, and the work that Dr. Berwick is doing is very encouraging; there's some great work being done by RAND and other academic centers on outcomes-based systems and what not that we are all looking at. We feel that there are some inherent quality mechanisms that have already been adopted in the plans, particularly the group and staff models, where they practice together in Kaiser.

Chairman **Stark**. There is very little aggregate data, as I understand it, from either your association or the industry or HCFA—and I'm not accusing; we just don't have much data. It's very difficult for us to make empirical decisions when the data isn't there.

Mr. **Doherty**. That's a very legitimate complaint, and we are all trying to develop the research capabilities now. We represent less than 10 percent of the population, and it's very difficult——

Chairman **Stark**. Would your association endorse a reporting requirement on all health care providers? It's obvious that the Federal Government is the centralized place to do it and has certain protections for confidentiality that you couldn't get anywhere else. I assume your association will endorse Mr. Gradison's and my idea of a reporting system for all hospitals and providers. Is that a correct assumption?

Mr. **Doherty**. I've got children; I can't endorse that right now, until the entire health care——

Chairman **Stark**. Well, I certainly hope that will be on the agenda of your association.

Mr. **Doherty**. It's obviously a very good idea.

Chairman **Stark**. That's what we like to hear.

Mr. **Doherty**. You know, the problem I guess that I have is that you have to understand that outside of Kaiser this HMO movement or industry is still a nascent industry, and we haven't developed the sophisticated research tools that you require—but we are making great strides in that direction. We are now doing detailed member plan surveys which we are trying to make as objective as we can, and trying to make them as detailed as we can. There are certain areas that we haven't been able to go into. We've developed a comparative data set which our plans can buy into on their actual performance and operation, and we are initiating the work in quality.

Chairman STARK. Help me with this little problem. Let's go back to the Fallon system. Are the Fallon system physicians reimbursed on a salary?

Mr. BELL. The clinic pays the physicians' salaries, and the health plan capitates the clinic.

Chairman STARK. But the doctors get a salary?

Mr. BELL. A salary.

Chairman STARK. Now, do they also have a profit participation?

Mr. BELL. There are bonuses that can be distributed.

Chairman STARK. Are those bonuses determined on the overall financial results of the plan, or is there another system?

Mr. BELL. It's a fairly complex system. If there is a bonus it's based on the overall performance of the clinic for the risks it takes. To an individual physician there is a whole series of factors that are entered into the individual physician's bonus. There is a small incentive for productivity that declines over time, because you can be too productive and that can compromise quality. In addition, there is quality input, there is patient-satisfaction input, there is cooperation in terms of peers, colleagues, utilization function, et cetera—and all are entered into this.

Chairman STARK. Mr. Bell—I don't know quite how to say this—is this a formula or is this a set of guidelines that, say, a committee does in reviewing? Is it a fairly abstract approach, or can you plug those numbers into your IBM and come out with $18.93 worth of bonus?

Mr. BELL. Actually, prior to being president of the Fallon Clinic, Dr. Podbielski was treasurer and was intimately involved in this, and he may be the best person to answer the question directly how the bonus is determined.

Chairman STARK. It's a problem that we have facing us, as you all well know. We have a hold right now on these reimbursement contracts, and it's a dilemma. You can be of some help to us if you can shed some light on this dilemma.

Dr. PODBIELSKI. Physicians are paid a salary, and the organization at the end of the year looks and sees how it's done financially, and then a certain amount of money is set aside for bonuses. And bonuses are determined partly by productivity, partly by quality. We feel we all should share equally in our success. And very recently we took a very hard look at quality of service. We are in a very competitive environment where we deliver our health care, and it's important that our physicians are looked at as to whether they are on time and how they interrelate with patients, how quickly they return their phone messages——

Chairman STARK. They must hate that.

Dr. PODBIELSKI. No, as a matter of fact, they don't. And we know that the physicians we choose—and we have a very careful credentialing process—are very quality physicians. But what's also important to us—and we put a financial kick into it—is the quality of service they deliver.

Chairman STARK. Let me just pick some hypothetical instincts here. We've heard a lot of testimony—not relating to HMO's—that pediatricians may make $60,000 a year, an aggressive ophthalmologist could make $600,000—maybe I shouldn't pick them, but that's just an example.

Do you have that big a spread in your compensation? You may have senior partners who have management responsibilities but among your practicing physicians, what's the spread of compensation?

Dr. PODBIELSKI. I do not feel that the spread in our organization is anywhere near what it is in the community. We have to recognize market forces. It's a fact that radiologists and ophthalmologists make more than pediatricians—and we recognize that fact, otherwise we wouldn't be able to hire those types of physicians. I think the problem in the community is magnified, and we try to deemphasize that.

Chairman STARK. Well, let me ask it another way. Among those physicians whose income is from procedures, I mean, whether it's reading an x ray or doing a certain surgical procedure, or a test—does your compensation program, as near as you can determine, remove any incentive to do extra procedures?

Dr. PODBIELSKI. We try to do that. You have to recognize it in some degree, but it's again not anywhere near what it is in the fee-for-service sector. We have, for example, a given amount of dollars that we assign to a department, and say those are your dollars to function with. So we really want the procedures that are done to be appropriate.

Chairman STARK. So if the department could, it might just as well hire an additional surgeon rather than some guy, say, who would say, "Gee, I'm going to do twice as many procedures and double my income." Your system takes that out of the equation.

Dr. PODBIELSKI. Yes, we don't encourage excess.

Chairman STARK. Well, I appreciate your testimony—and I know that you were here when the other witnesses were here, and I think you understand our dilemma. There are, I suspect, ways that the system, not individual operators, but the system can select against us, and there have got to be incentives, even in the most nonprofit charitable sort of environment, to avoid those problems. Unless there is some incentive, either in the charter or the charge of the HMO, to say let's go out and find every high-cost patient in the community and bring them in, maybe there are institutions who do that.

Mr. DOHERTY. When the AAPCC was first developed, it was designed to try and take care of these things through adjustments, and it hasn't worked, as Mr. Bell has indicated. The other thing is I think you deserve high marks, sir, because you have identified, through your questioning of some of the incentive programs and what not, that the quality is an issue, and I think that you have speeded up the work a great deal in terms of developing quality assurance systems that will make sure that there isn't the kind of skimping on care that you fear.

Chairman STARK. Thank you, but you really touch on our problem, and that is that we have to write into legislation, or review regulations, that deals with every person in the country. There are amazingly different procedures and traditions and costs, and therein is our biggest problem. I mean, we could probably sort out your premier members in premier communities where access and quality and costs all blend into a wonderful Camelot of high-quality care at low cost.

But the horror stories still exist, lack of not only access but facilities.

Mr. **Doherty**. There are 700 HMO's in the country and all of them have their own incentive systems and their own reimbursement mechanisms, and therefore you have to measure those in the light of quality and it becomes a highly subjective, difficult job.

Chairman **Stark**. Can you gentlemen live with a standardized Federal formula, assuming that is maybe a third of your business—just a guess—on reimbursement, quality, and access?

Mr. **Doherty**. Sure, if one can be worked out, but my frustration has been in the area of quality, that every time you talk to somebody about standardized quality, they tell you you are a decade away.

Chairman **Stark**. But, you know, every time I talk about quality of care with the AMA, they talk about higher fees.

Mr. **Doherty**. We already live under a fairly standardized reimbursement mechanism under the AAPCC. It's I think the quality area that really deserves the attention. You know, the fees are going to take care of themselves.

Chairman **Stark**. But you can't take access out of there either. Because I can make quality inexpensive if I limit access by the obviously expensive cases, I think we all agree to that.

Mr. **Doherty**. I think the number that Dr. Berwick gave is a very impressive number, 1.2 million out of 433; I mean, it's more than I make in a week, but nonetheless it's not really that much money that they are putting into it, and, as you indicated, they have one of the finest quality assurance systems in the country.

Chairman **Stark**. That's what I've been led to believe.

Mr. **Doherty**. I'm not too sure that it's all that expensive, and in the long run I am not too sure that——

Chairman **Stark**. I think what I heard in Dr. Berwick's testimony is that is not the problem of the computer systems and the formulas; it's the problem of the culture that says this is what we are going to do, gang. That comes first. And everybody in the organization says I'm with you. The minute you have an organization or an individual or an incentive program that doesn't focus on that, I'm not sure that Harvard system would work.

I think it was mentioned in California—the IPA's—that these are a bunch of lone gunslingers out there just banding together to fight the bad guys once or twice at the corral, and then they all go their own way. And I'm not sure that his system would work in some other climate. I don't mean that it's necessarily a profit climate; I'm just saying that I'm not sure that will always be the case.

I appreciate very much your patience in being here and your willingness to share with us. We are going to ask you in the future to provide us with more data that we don't already have and I would appreciate your willingness to work with us and provide as much data as your members are willing to give and still keep you all in office.

Thank you very much.

The committee is adjourned.

[Whereupon at 1:18 p.m., the hearing was adjourned.]

APPENDIX

Theory and practice for measuring health care quality

by Donald M. Berwick and Marian Gilbert Knapp

As competition, cost control, and new modes of delivery emerge in health care, there is a need to reexamine both the traditional definitions of health care quality and the methods by which it is measured.

Industries other than health care have much to teach regarding the methods for obtaining, analyzing, and displaying data; techniques for problem identification, problem solving, and reassessment; and ideas about organizational factors that produce a high quality product or service. The Quality-of-Care Measurement Department at the Harvard Community Health Plan has built a program that draws from a distinguished health care quality assurance tradition and incorporates techniques that have been successful in other industries.

Introduction

Quality assurance in health care is an enterprise strangely disconnected from the object of its study. Despite a distinguished intellectual tradition now decades old, the routine assessment of quality is rarely linked with the day-to-day management of health care systems or with the decisions made by individual and aggregate purchasers of health care. In other industries, it would be unacceptable for such a situation to exist. It would be as if neither the producers nor the buyers of automobiles regularly assessed, for purposes of making their decisions, whether the cars they made and bought ran reliably and well.

New directions in the delivery of health care are pressing the industry to reevaluate how quality is assessed, to consider how information about the quality of care delivered may ultimately be used, and to challenge existing notions of the definitions of quality. Health care in managed care systems, competition, regulation of cost, resource constraints, and new regulations are changing how care is provided. We are reducing the length and frequency of hospital stays, cutting capital and operating margins, and forcing economies in ambulatory care. Corporate producers of health care, profit and not for profit, seem somehow threatening to the traditional model of the individual doctor serving the individual patient. In the course of things, we are unmasking enormous variation in the patterns of care from region to region and from doctor to doctor, and there is the temptation to conclude that the lowest resource users provide a goal towards which all should strive.

Important questions have been raised demanding thoughtful answers. Physicians and patients ask about the sanctity of the doctor-patient relationship; patient advocates fear that needed care may be withheld if there is money to be saved; patients ask if the lowest cost care is really the best; and the purchasers of care for groups wonder which is the best choice for their clients. The current state of the art in health care quality assessment does not offer tools to answer these concerns. We cannot currently tell wise decisions from faulted ones; we cannot choose those economies that leave patients safe and satisfied and avoid those which unacceptably damage care. The development of a quality measurement system is now an urgent agenda in health care. Meeting the need for managerially relevant quality assessment in health care requires new perspectives and new tools. The field to date has built a respectable array of resources, some of which can be incorporated into future designs, but the resources do not yet form a pattern.

To build the future, it is useful both to review the past experience in health care quality assurance and also to look to other industries that have long histories in the assessment of quality.

History

Modern quality assurance in health care has two central strands of inquiry. One seeks definition of the object of scrutiny: What exactly is to be studied? The other seeks methods: How to study quality. The dominant figure in the first areas is Avedis Donabedian, considered by many the father of the academic enterprise of quality assessment in health, and the author of a recently completed three-volume summary of the field as of the early 1980's (Donabedian, 1980, 1982, and 1985). Donabedian, among others, offered the categories of "structure," "process," and "outcome" as the three classes of potential objects of investigation (Donabedian, 1966). "Structure" is a general term for the nature of the resources that, assembled, provide health care, including, for example, the mix of manpower, the credentials of the providers, the facilities, and the rules of procedure. "Process" refers to intermediate products of care, such as patterns of diagnostic evaluation, access to care, rate of utilization, and choice of therapies. "Outcomes" are end products of care, the health status, longevity, comfort, and, perhaps, the satisfaction of its clients.

Traditionally, structure, process, and outcome are, in that order, increasingly difficult to study and increasingly important. Indeed, many investigators in the field have assumed, tacitly or explicitly, that the first two—structure and process—are appropriate objects of scrutiny only to the extent that they are demonstrably related to valued outcomes. Through

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Reprint requests: Marian Gilbert Knapp, M.A., Department of Quality of Care Measurement, Harvard Community Health Plan, P. O. Box 9100, Brookline Village, Massachusetts 02147 this logic, quality measurement has been closely associated with such other domains of research as technology assessment, clinical evaluation, and randomized clinical trials, enterprises that seek to prove that certain processes (or resources) yield particular outcomes.

The second major theme in the quality assessment literature deals with methods of investigation: Having chosen an object of scrutiny, how good is the performance? Three general methods have been explored over time: implicit review (Hulka, Romm, Parkerson, et al., 1979; Moorehead et al., 1964, 1967), explicit review (Brook and Appel, 1973; Brook, 1973; Lembcke, 1956; Fitzpatrick, Riedel, and Payne, 1962; Payne, Lyons, Dwarshius et al., 1976; Williamson, 1971), and the use of sentinels (Lembcke, 1967; Sheps, 1955; Ciocco et al., 1950; Ciocco, 1960; Rutstein, Berenberg, Chalmers, et al., 1976). Implicit review processes use experts who are able to recognize good care (structure, process, or outcome) when it occurs, or, in some cases, groups whose joint knowledge or judgment is thought better than any individual's. Implicit review procedures may assign scores to records of care or otherwise judge in global terms how well a system or provider dealt with individual cases or groups of patients. Both explicit and implicit reviews may involve sophisticated group techniques for selecting problems for review and for forming consensus on the quality of care.

Explicit review involves specifying criteria for care and review of records or observations to check on the degree to which what happens conforms to these prior criteria. By its nature, explicit review is better suited than implicit review to using nonprofessional staff to conduct the actual reviews of care. Professionals (often using group discussion or implicit techniques) write the standards and train nonprofessionals to rate the care. Explicit review has the advantage of clarity, compared with implicit review, but the disadvantage of oversimplification and, in the worst examples, clinical irrelevance. Recent researchers have attempted to modify review procedures to incorporate clinical algorithms and branching logic into criteria maps (Greenfield, Lewis, Kaplan, et al., 1975), as distinguished from simple criteria lists (Payne, Lyons, Dwarshius, et al., 1976), in the hope that the more complex rules for rating care may produce results that are clinically more plausible and useful. In one report (Greenfield et al, 1981), criteria maps were, indeed, shown to be superior to lists in predicting which clinicians made correct decisions in sorting chest pain patients who required hospital admission from those who did not.

Implicit and explicit review have remained largely separate streams partly because they seem to produce different results. In direct head-to-head comparisons, explicit and implicit reviews of the same cases have yielded some significant discrepancies in ratings (Hulka, Romm, Parkerson, et al., 1979). Which is superior is a matter of continuing debate, with practicing physicians, in general, favoring implicit processes and managers and regulators favoring explicit criteria and scoring systems.

A third, somewhat different, school of method proposes the use of sentinels as the major form of quality review. The advocates of this technique attempt to define classes of unacceptable or red-flag events and then to perform detailed investigations of the events, using implicit or explicit methods. Such case reviews can range freely among issues of structure, process, and outcome; and they can address problems at individual or systemic levels. Perhaps the clearest such model is the morbidity and mortality rounds held in many departments of surgery, but other schemes have been proposed at larger scales. To some extent, the review techniques developed and recommended by Wennberg and his colleagues (Wennberg and Gittelsohn, 1982), who search particularly for statistical outliers in rates of utilization, are connected with this notion of surveillance for sentinel events. Sentinel events can also be used directly as indicators of quality when they are judged to be outcomes that ought to be avoided by a sound health care system.

Donabedian's three volumes (Donabedian, 1980, 1982, and 1985), in which the field of quality assessment in health care is summarized, provide an impressive pedigree. Why then is quality assessment not yet in the life's blood of health care? Why, if we ask whether cost containment is hurting quality, or whether health maintenance organization "A" is better than health maintenance organization "B," must our answers be so impoverished, or at least so anecdotal? What should happen next in the field if the measurers are to become more useful to those who manage health care—for example, physicians and other health professionals; clinical department managers and chiefs of service; medical and administrative facilities managers; regulators; purchasers of care; and patients who more and more will wish to exercise choice in managing their own health care? A logical next step for health care assessment is to look to other industries to learn from their experience, their successes, their techniques, and perhaps their failures.

Learning from other industries

Other industries have a long history of assessing quality and use measurement more self-consciously and systematically than health care does. Industrial quality measurement techniques have benefited from nearly five decades of trial, development, evaluation, and reevaluation on the way to their current state of sophistication.

The discipline of industrial quality control has drawn energy from the pressures of the marketplace and the demand of consumers that products and services be continually improved. Similar pressures now confront health care providers, and important lessons lie in the extensive experience of other industries in the applied technology of quality control and assurance (Crosby, 1979; Juran, 1964; Deming, 1982).

Lesson I: Importance of design

In the history of industrial quality assessment and control, the first quality assessor was the consumer. A product was usually distributed without being subjected to a quality control process, and the only mechanism for knowing if the product was unacceptable was if the consumer complained or abandoned it. In time, industry's response was to institute systems that would attempt to intercept substandard products before they were distributed in order to prevent abrasion of consumers and loss of market share.

As health care delivery has become more organized and more competitive over the past decade, consumers of health care now have the opportunity to select among care delivery systems to find one that best meets their needs. Health care is learning, as other industries have learned, that to use consumer dissatisfaction as an index of quality is both hazardous and costly.

Early internal quality control mechanisms placed an inspector at the end of a production line to weed out those items that did not meet a specific set of criteria. Completed products that might in some way harm the consumer or cause dissatisfaction were discarded before they could reach the marketplace. Although this system may prevent the consumer from receiving faulty goods, it is a costly form of quality control. It offers some protection for the consumer, but, because unacceptable products are still beng produced, risks are high. In addition, such inspection systems do little to correct inefficiences throughout the line of production, may displace responsibility for meeting criteria to a separate entity remote from the production line, and require that the ultimate cost of the product be higher than necessary.

Recent advances in industrial quality assessment and control concepts have moved responsibility for identifying and fixing problems further and further up the production line. Quality control mechanisms are more and more being placed at interim stages in the production process. Modern quality control engineers now try to control quality in the actual design of the product. Corporate mottos such as "Do it Right the First Time" or "Quality by Design" are not just slogans for boosting morale; they also reflect modern notions of the most efficient strategies for quality assurance. High quality design is more efficient in the long run than thorough inspection at the end of the production line is.

Lesson II: Multidimensionality of quality

As industrial quality control has come to understand the importance of higher quality in design, so also has it come to regard the quality of a product or service as a fundamentally multidimensional concept. Here, too, health care can learn from other industries.

Over the past few decades, quality assurance in health care has invested heavily in efforts to demonstrate the relationships between the elements of care—structure and process—and the outcomes of care. The assumption that better health care produces better health outcomes has been the foundation of much of the search for operational definitions of quality. According to this view, the measurement of process is actually a surrogate for the measurement of the real goals of health care: improved health status, function, and comfort.

Making health status outcome so central to the definition of quality has at least three serious limitations. First, it burdens the exploration of quality with the agenda of virtually all clinical and health services research. If assuring quality means assuring that what we do really works, then we can only assess quality when the production functions are known. As Donabedian (1980) has pointed out, if we know the relationship between, say, process and outcome, then measuring process is quite acceptable as a surrogate for measuring outcomes. If we do not know the relationship between process and outcome, then measuring outcome is not a useful indicator of system quality, because we cannot use the information to determine which aspects of process to preserve and which to change. On reflection, making an understanding of effectiveness a prerequisite for measuring quality is probably a formula for paralysis. We simply know too little today about what in health care actually does produce health.

Second, there is good reason to believe that a great proportion of health care probably does very little to alter the course of illness or to preserve life or function. In the average ambulatory encounter, at least, the physician is usually dealing with acute, self-limited diseases for which definitive treatments do not exist and for which a wide variety of diagnostic and therapeutic strategies are equally innocuous. For many encounters, the patient's major objective is to gain reassurance, to feel cared about or listened to, or to undergo a nearly ritualistic ruling out of unlikely major diseases. Unless we define outcome very broadly, to include many elements of the patient's feelings, attitudes, and satisfaction, then the tyranny of outcome in defining quality risks calling much of the activity in health care wasteful, useless, and scientifically unsupported. But doctors and patients know better; they know that, often, what health care delivers is not outcome—in the sense of improved longevity or function—but rather process, itself.

In this regard, health care is like other important consumer goods. The quality of an airplane flight lies foremost in a safe conclusion, but it also connotes the ability to obtain a reservation at a time when it is needed, the courtesy of the staff at each contact, the ease of making connecting flights, and the quality of the food. Such a broader notion of quality, incorporating many different and potentially independent dimensions, raises the important possibility that reasonable and fully informed people may disagree about the quality of a health care provider and goes far beyond the simpler notion that the quality of a health system is coextensive with its safety or ability to produce longer life.

Lesson III: Importance of organizational culture

Quality assurance in other industries has now moved back through the production or service line into the very structure of the organization. Industry has learned that, in order for quality assessment to be effective and efficient, it is not enough to develop new techniques of measurement and control to be implemented at various points of manufacture but that there also must be an investment in a corporate culture geared towards producing a high quality product. Industries have silenced arguments against the cost of quality assurance mechanisms as they have learned that, although such systems do require an investment, they return high dividends through reduced customer attrition, through fewer losses from unusable products and less need for rework, and through greater efficiency in the production process. Commitment from senior managers to invest in producing a high quality product is one key to successful quality control. Managers must commit to assisting every employee to improve quality continually. Resources must be available to develop ways of identifying and fixing problems. Goals must be clearly stated, with mechanism to assure that they are understood by all. Employees must have the means to meet these goals and adequate training to enable them to do their jobs effectively. Objective measurement is necessary to know whether goals are being met and where improvement is most feasible. Feedback of the results of measurement must be prompt and must reach those managers, supervisors, and other staff who are responsible for production. Reports must appear in clear, useful, and usable format.

Health care can also learn lessons from other industries about the ways in which measurement data are collected and about the statistical techniques used for analysis. Traditionally in health care quality assurance, the primary source of data for the assessment has been the medical record. Although rich in information, the medical record as an assessment source is widely acknowledged as being flawed by differences in record keeping systems and variations in recording practices. With health care now expanding its view of what constitutes care in an organized delivery system, it can draw upon methods for collecting data such as those used in service industries—banks, hotels, or airlines. Service industries use three techniques, in particular, that deserve increased exploration in health care: surveys, observations, and simulations.

Perhaps the greatest achievements of industrial quality assurance lie in the practical statistical methods that have been developed for sampling and for modeling performance. Like health care, for example, many industries face the challenge of finding flaws that are extremely rare. Industrial quality control engineers use well-developed techniques for calculation of failure time or of the probability of deficiency, yet these same techniques are rarely used in the assessment of health care. Industrial quality assurance pays strict attention not only to average performance but to variance and loss functions which include terms for reliability. Health care, too, ought to be sensitive, not just to the average performance level of a person or system but also to the variability in that performance.

The time is ripe for some new directions in quality measurement in health care. The next decade of development should not only draw on the distinguished intellectual achievements of the field but should seek, as well, to make the measurement enterprise more useful to the managers and decisionmakers whose choices and strategies will shape the system we shall pass on to the 21st century. Other industries have much to teach us, if we will think inventively about analogies and similarities. To fail to develop ways to measure and publish wisely the performance of our health care systems will place us at the mercy of ill-informed choices, and may, in the end, cause sacrifice of the legacy of caring that we should seek to preserve.

Harvard Community Health Plan

At the Harvard Community Health Plan (HCHP), a 300,000 member staff model health maintenance organization (HMO) located in the greater Boston area, the Quality of Care Measurement Program has begun to supplement traditional concepts and methods in health care quality assessment with new approaches, applicable new models, and management needs in health care delivery systems. Using concepts and techniques from a variety of industrial settings, the quality assessment function has been relocated in the corporate structure, has expanded its view of the very definition of quality, and is now developing new technical methods for obtaining data, conducting analyses, and producing reports.

HCHP's Quality of Care Measurement (QCM) Program has a reporting relationship to the highest internal policymaking levels. This position declares and emphasizes that the commitment to providing high quality care is a serious endeavor valued by the corporation as a total system for delivery of care. Further, renaming the former quality assurance program "Quality of Care Measurement" emphasizes the distinction between assurance and measurement. The assurers of care are the providers of care, the physicians, nurses, technicians, and support staff who, on a day-to-day basis, manage the care and service provided to patients, along with the other staff and managers who create the environment in which sound care is possible. The measurers of care provide objective information that is useful to the clinicians as an aid to practice management.

HCHP has embraced a multidimensional view of quality defined from multiple perspectives, including that of the consumer. In the Quality-of-Care

Measurement Department, new techniques of gathering data, such as observation, simulation, and patient survey, are being rigorously designed and tested to develop new methodologies that will supplement traditional ones.

Redesign of the quality measurement program at Harvard Community Health Plan began with a specific conceptual framework for the definition of health care quality and a conviction that any system of assessment should focus on those attributes of care that the Harvard Community Health Plan values for its members and that integrates both professional and lay views of the elements of high quality.

The primary components of the definition of quality remain excellent technical care and favorable health status outcomes. However, other areas of performance, such as providing access to care, receive high weight as additional important aspects of quality. The multidimensional view of quality Harvard Community Health Plan includes, at a minimum, measures of technical process, health status, outcome, access, coordination of care, ambiance, interpersonal relationships and satisfaction, support staff training, and staff morale and satisfaction.

Because the Harvard Community Health Plan offers many different products of care (encounters with well patients, care of those with symptoms, care for emergency problems, hospitalizations, psychotherapy, perinatal care, and encounters in such intermediate care areas as laboratories, pharmacies, and radiology suites), the Quality of Care measurement program may measure performance in each type of encounter with respect to any of the relevant attributes of care. For each type of encounter, different attributes may deserve different weights: technical process is more important than interpersonal demeanor in a cardiac arrest, but interpersonal qualities may be much more highly valued in a well-child care visit, where the risks of faulty process are much lower and reassurance is often a key goal. Each system (indeed, each patient) may attach different weights to these desired attributes, and intelligent, completely informed consumers may rationally disagree about which of two systems demonstrates better overall quality.

This multidimensional view of the quality of care raises important issues of measurement. Medical records are the traditional source documents for the assessment of outcomes and technical process, but they are not useful for the assessment of such other dimensions as access, interpersonal care, or ambiance. New dimensions require new measurement strategies.

Primary among these strategies and tools are surveys to obtain information about patients' perceptions of care received. Building on work done by other health service researchers, the Harvard Community Health Plan is developing and using scaled questionnaires that can help consumers of health care tell about the care they received. Items on these questionnaires ask about appointment access, waiting time in the waiting room, ambiance, support staff warmth, provider warmth, provider skill, continuity of care, the patients' sense of sharing in the control of care, and a summative satisfaction rating. In addition, members are asked about their intention to keep the same health care provider and the intention to remain an HMO member.

The Quality of Care measurement program currently uses two modes for administering these questionnaires. One type of instrument is administered onsite in clinical units as patients exit from their visits; the intent is to gather immediate impressions of the encounter and to focus on the single care event. Collection occurs at regular cycles throughout the year, and attempts are made to collect a completed survey from each visitor. Response rates using this technique range from 75 percent to 90 percent. All Harvard Community Health Plan sites are surveyed during the same time period to assure comparability and reduce confounding effects of events outside of the HMO's control—such as bad weather. Once collected, the data from several thousand surveys are entered into a microcomputer system and analyzed using standard statistical packages.

The other form of survey administration is through the mail. Harvard Community Health Plan uses mailed questionnaires primarily for evaluating services that do not occur onsite, such as hospitalizations. Specialized surveys have, so far, been developed for medical and obstetrical hospitalizations. Hospital surveys have a broader focus than the visit surveys; during the obstetrical survey, for example, patients are asked to rate their prenatal care, initial labor contact, hospital admission process, labor and delivery care, postpartum care, hospital ambiance, patient education, and length of stay. In addition, patients rate the various clinicians they see, such as obstetricians during pregnancy, nurses in labor and delivery, and pediatricians in the hospital.

All surveys include demographic information such as age, gender, length of HMO membership, race, socioeconomic status, and whether the HMO visit was for well or sick care. Where appropriate, these data are used as covariates in stratified analyses.

Once survey data are collected, the turnaround time for data entry, analysis, and report generation is less than 4 weeks. The goal of most Quality of Care Measurement work is to give information to involved managers and clinicians in a time frame consistent with their management needs. Survey reports go first to the chiefs and supervisors of involved services and thereafter to the medical directors of facilities and to other senior level managers.

Direct observation as a data collection technique has been little explored in health care quality assurance, though observation is a common method of assessment of service in the hotel and airline industries, in which trained observers sample actual transactions and rate them according to previously established criteria. At the Harvard Community Health Plan, observations have been used to rate the quality of the ambiance of the facilities. Observers use rating forms (modeled on those used by the hotel industry) to gather observations about cleanliness of public areas, noise levels, protection of patient privacy, and clarity of signs. Observations of service behaviors among support staff have also begun.

Simulations pose much greater difficulties but also hold greater promise. They are used routinely in some service industries where trained individuals pose as users and report on what customers actually experience. Harvard Community Health Plan has proceeded cautiously in the use of simulated clinical events. Initial efforts have included attempts to schedule simulated appointments for a variety of types of visit. Quality-of-Care Measurement staff are trained in the use of written scenarios that request appointments for routine or urgent visits. Appointments are made and then immediately cancelled. Such simulations offer a realistic view of a member's attempt to get an appointment and afford a better estimate of true access than do more traditional nonintrusive methods.

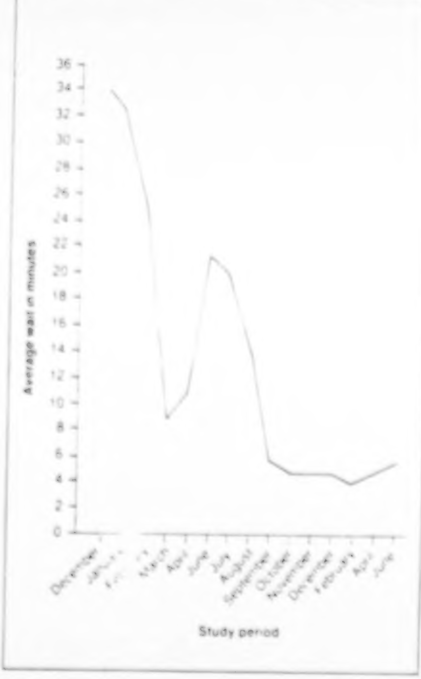
Displaying information in a digestible format, one that is easily grasped in one glance, has been an important goal of the QCM Program, which continues to experiment with various display methods. Figure 1 shows data collected on waiting times in an HCHP unit.

In December 1985, QCM data and member comments indicated a problem with extended waiting times. Once the problem was clearly documented, managers attempted to determine the probable cause of the problem and to recommend a solution, which required restructuring the workflow during the winter of 1986. During February, the waiting times dropped from an average of 34 minutes to 10 minutes. During the spring and summer, installation of a new computer system caused a rise again in waiting times, but by September the new systems were in place. Waiting times remained constant thereafter at an acceptable level, and member complaints ceased. Regular measurements using standardized procedures displayed in simple formats have been standards in industry for decades. In many instances, as in this example, these techniques are easily transferred to a health care setting. They can help managers identify problems, measure trends, and demonstrate improved performance.

Measures of technical process and outcome, still the most important dimensions of quality, are being developed to ensure the capture of accurate, consistent data. Working closely with senior medical managers and clinician groups to formulate criteria and standards of care, QCM designs mechanisms to measure performance against such criteria. Currently, clinical data are collected in a number of routine ways, some involving searches through Harvard Community Health Plan's automated medical record systems and some involving detailed, traditional explicit manual reviews. Computer programs have been written for the automated medical record to identify categories of patients whose records are then scanned to determine if appropriate management has occurred. For example, software in the automated record system identifies women with abnormal pap smears and automatically notifies clinicians if appropriate followup has not occurred in a time interval specified by Harvard Community Health Plan clinical staff. Similar systems exist for following up negative rubella screens, diabetic patients, patients on lithium, patients on coumadin, and children with urinary tract infections. These reminders to the physicians have been designed primarily as a tool for physicians to use in managing patients, but the program also collects data on the proportion of patients whose care meets the established criteria.

A data-base system that has been built on a microcomputer now includes information on all recent Harvard Community Health Plan deliveries—approximately 2,000 births so far. Reports are generated from this system to display prenatal care patterns, Cesarean section rates, complication rates, rates of high-risk pregnancies, birth weights, and neonatal death rates.

Figure 1
Average patient waiting time in the same care delivery unit for selected months: 1985-87



The examples mentioned here provide an overview of the type of work underway at HCHP. Goals in the short term are to develop measurements in all of the identified dimensions of quality, to test them, assess their value, eliminate those that are not viewed as being useful, and, ultimately, to weight dimensions according to their importance to provider and patient populations.

In addition to its general measurement activities the Quality-of-Care Measurement Department also organizes case reviews of significant incidents. These indepth studies have proven very useful in identifying broad inefficiencies in systems or areas of potential hazard. Although much more subjective in nature, the historical reconstruction of a failure reveals rich information about how, when, and where problems are most likely to arise. Quality-of-Care Measurement staff also initiate and assist in the design and implementation of special projects, serve on organization-wide task forces, and consult with HMO staff in a large variety of situations, often with committees of managers and clinicians organized at local care sites.

The Quality-of-Care Measurement effort at Harvard Community Health Plan, though innovative in some respects, has taken only the first steps towards a truly applied technology for quality assessment and control in health care. In full flower, such a technology would offer a wide range of tools, tested for validity and reliability, to assess quality in its several dimensions and to display results in formats familiar and friendly to purchasers and producers of care. It would, further, fit comfortably into an overall organizational strategy for quality control, in which measurement is not an end but a means for continual improvement of health care and of the systems which produce that care.

Acknowledgments

The authors are grateful to Ms. Deborah Alessi for her assistance in preparation of this article.

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[Submissions for the record follow:]

Statement of the American Medical Peer Review Association
Before the Subcommittee on Health
of the House Committee on Ways and Means
on Medicare Capitation Initiatives

March 10, 1988

Mr. Chairman, the American Medical Peer Review Association (AMPRA) is the national association of physician-based medical review organizations and of the Peer Review Organizations (PROs) under contract to the Medicare program. Our membership also includes all but one of the contractors who were selected as quality review organizations (QROs) to monitor the quality of services provided to Medicare beneficiaries enrolled in health maintenance organizations (HMOs) and competitive medical plans (CMPs).

We appreciate your interest in the performance of the Medicare risk contractors, and your support for objective, external quality review of all health delivery organizations. Our membership has long supported the appropriateness of managed care systems including those in which the financial risk for the provision of services is shifted to the provider through a capitation payment arrangement. Because of our experience with the delivery of health services under a variety of payment arrangements, we also believe strongly in the value of an external peer review program to examine objectively the quality of care in both ambulatory and institutional settings.

Overview of PRO Involvement with Review of HMOS/CMPs

The Omnibus Reconciliation Act of 1986 (OBRA 86) required competitive bids for HMO/CMP review contracts in up to 25 states. The law awarded automatic review contracts to PROs in the remaining states. The effective date for the start of review was set at April 1, 1987.

In the last year, HCFA successfully implemented the provisions of the OBRA 86 legislation through a competitive bidding and contract modification process. In all but two of the competitively bid states the contract was awarded to a PRO. Key components of the HMO/CMP review plan are:

- review of both inpatient and outpatient records for 13 sentinel inpatient conditions that may indicate ambulatory outpatient care;
- a 3% random sample of inpatient cases;
- review of all deaths;
- review of transfers from non HMO/CMP contracting hospitals to hospitals under contract with HMO/CMPs;
- review of readmissions within 30 days and any intervening care delivered during the 30-day time period.

HCFA delayed the commencement of focused ambulatory review until PROs are six months into their HMO review contracts. Review organizations were asked to submit ambulatory review proposals for HCFA approval.

In the fall of 1987, AMPRA along with representatives from the HMO industry established a working Task Force to assist in the design of ambulatory review methodologies that might be employed by review organizations. HCFA has supported this effort through purchase order requests. The first formal recommendation from the first Task Force to HCFA and the PROs was an interim ambulatory review plan based on a random selection of cases for review. The Task Force concluded that a fully developed "focused" review plan is dependent on the establishment of a uniform ambulatory data system that is not currently in place. The interim review plan is currently under consideration by HCFA. Other Task Force projects will include recommendations on medical criteria to be used in reviewing the 13 sentinel conditions and the development of a uniform ambulatory data system.

Mr. Chairman, three years after the inauguration of the Medicare risk contract program we have only just begun actual PRO review HMOs and CMPs. We have been disappointed in delays, both political and technical in nature, that have prevented a more timely implementation schedule. There are still formidable obstacles to the conduct of external review in these settings, and in the balance of our statement we want to share with you some remaining problems and ask for your assistance in moving this activity forward.

Implementation Problems

There are nearly one million Medicare beneficiaries enrolled in risk-based HMOs and CMPs. Under the new or modified contracts for the conduct of peer review in these settings, emphasis has been placed on the review of hospitalizations. Hospital based review is facilitated by the fact there is a uniform data set created by hospital submission of UB-82 or Medicare hospital claim form to program fiscal intermediaries (FIs).

Unfortunately, PROs have found that many hospitals are either not submitting or submitting an incomplete claim form to the FI for HMO admissions since hospital payment for the admission flows from the HMO not the FI. There is no incentive for the hospital or the HMO to ensure that the claim form is completed and contracts between HMOs and hospitals do not include this feature. Thus, many such admissions now go undetected because these so-called "no-pay bills" are not filed.

Compliance by HMOs, hospitals and FIs needs to be improved in order to permit an effective external review program to function. We believe that HCFA should require HMOs to have working agreements with their contracted hospitals that guarantee the submission of complete claim forms to the FI. The FI must then be required to program their systems to receive these "no pay" bills and segregate them by individual HMO/CMP plan identification. Without these mandates, it will not be possible to apply the same scrutiny to the hospital care received by beneficiaries enrolled in HMOs and CMPs as that given to all other Medicare hospital admissions. Further delays in review cannot be tolerated.

Another information retrieval problem that PROs have encountered in implementing HMO/CMP review concerns the collection of ambulatory medical records for review. It has been PRO experience that IPA model HMOs are having difficulty in collecting the office records of participating physicians that PROs must access to complete their required reviews. We are hoping that this problem will soon dissipate as IPA HMOs begin to educate their physicians regarding the mandates of PRO review.

The arena of ambulatory care review represents a new frontier and a significant challenge for review organizations and for the HMOs/CMPs. As noted earlier, there is not a uniform ambulatory data base for HMOs/CMPs. Depending upon their organizational configuration HMOs/CMPs utilize a variety of reporting mechanisms to record clinical and financial information. For the most part, these data systems were designed without external peer review programs in mind, and lack uniformity. For some HMOs, particularly group practice models, there is no patient data beyond the individual medical record.

AMPRA is of the opinion that the ultimate goal of establishing a cost effective,, non-intrusive, focused ambulatory review system is dependent on the development of a uniform ambulatory patient encounter data system. We believe, therefore, that HCFA, as purchaser, should mandate a minimum data set by a date certain and make continuation of risk contracts dependent on compliance with such data reporting. At the same time we recognize that for a number of HMOs and CMPs these reporting requirements will increase costs, and that these increased costs are not accounted for in the capitation payment. Thus, HCFA should also provide for payment of the administrative costs related to this effort.

Once the data system becomes operational, we believe that ambulatory review can be carried out effectively and efficiently. Such a data base will permit the use of a focused review plan based on samples of patient encounters in clinic settings, in home care and in long-term care institutions. Nevertheless, there remain a large number of review methodological issues that have yet to be resolved. As more experience with this undertaking accumulates, we expect to identify further steps that HCFA and the Congress could take to ensure timely implementation of the PRO review mandate.

There is one other area that we believe needs more attention and that is the need for education of both health plans and beneficiaries. With respect to the plans, there is widespread mis-understanding of the role of PROs, the external review requirement, the obligation to furnish medical records, the confidentiality of the process, and the notice appeals requirements. Moreover, beneficiaries are often unaware of their rights after enrollment, the obligations of the health plan to furnish medical records for review, and the opportunity to direct complaints concerning HMO quality to the appropriate peer review organization. We expect to work with both groups in an effort to generate better understanding and support of the role of PROs.

Conclusions

Mr. Chairman, we again want to thank you for this opportunity to present out views and experience with respect to external review of HMOs and CMPs. Although we have encountered a number of difficulties in the implementation of medical review in these settings, we are confident that both the data and methodological challenges can be overcome. We want to state our support for the Medicare risk contracting program and the wider choices it makes available for Medicare beneficiaries. At the same time, we are committed to a vigorous and comprehensive quality assessment of the services provided by these organizations. We urge you to support a strong mandate from HCFA with respect to compliance with data reporting and to recognize the additional costs associated with this new data base. We also urge you to support research dollars that could be used to develop and refine ambulatory review methodologies.

We intend to keep you informed as to the outcome of review activity by our member organizations as soon as sufficient experience in the actual conduct of review accumulates. Thank you for your continuing interest in support for the PRO program.

STATEMENT OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

This statement is submitted by the Blue Cross and Blue Shield Association on behalf of its 77 member Plans throughout the United States. We appreciate this opportunity to provide comments to the subcommittee as it considers issues relating to capitation programs under Medicare.

In the private market, Blue Cross and Blue Shield Plans operate the nation's second-largest HMO network with 97 HMOs and the largest PPO network with 53 PPOs. With respect to Medicare, 22 Blue Cross and Blue Shield Plan HMOs and Competitive Medical Plans (CMPs) currently enroll 116,000 Medicare beneficiaries under 31 risk contracts. While this represents a significant level of participation in Medicare capitation programs, it is a decrease from previous levels. Because of financial losses and program instability, eight Plan HMOs/CMPs dropped a total of 15 Medicare risk contracts at the end of 1987, affecting 27,500 Medicare enrollees. Blue Cross and Blue Shield Plans continue to be a major force in the Medicare HMO/CMP market but increasingly are reassessing its viability. Based on our experience, we would like to address several major factors that we believe are limiting the use of Medicare capitation.

These factors include several technical deficiencies of the Adjusted Average Per Capita Cost (AAPCC), the potential for rate reductions under the Gramm-Rudman-Hollings Balanced Budget Act, and the uncertain legal status of physician incentive programs. We would like to comment in detail on each of these problems and suggest options to address them.

The Capitation Payment Method

Problems with the current payment method have been documented extensively by others, so we will describe them briefly. First, the AAPCC rate method does not take into account health or disability status. As a result, an HMO may be under or overpaid relative to the expected use of necessary health care by its enrollees. We are encouraged by HCFA's testing of the newly developed Diagnostic Cost Groups method. This method would adjust for beneficiary health status by taking into account non-discretionary hospitalizations. If this adjustment is found to be a valid, predictive measure of health status, its adoption could spur greater HMO participation by reducing the risk of enrolling a sicker-than-average population.

Second, setting rates on a county-by-county basis often leads to wide rate variations between contiguous counties and ignores intra-county variations in medical care costs. These variations can also result in payments that are too high or too low in relation to the risk an HMO assumes for its enrolled population. For several reasons, the county-based method also leads to substantial rate differences between urban and rural areas, which discourages HMO development in rural areas. To address these problems, we support setting rates based on ZIP code rather than county, and HCFA's testing of payment based on the utilization experience of specific prepaid entities rather than using county averages. Experience-based payments would reflect more accurately the prepaid entity's own utilization patterns. In addition, we support Senator Durenberger's proposals to adjust payments if an HMO's aged beneficiaries meet Medicare's disability criteria and to set minimum HMO payment rates for rural areas.

Finally, the annual rate updating method can result in major year-to-year payment changes that make financial planning very difficult. To address this problem, we endorse HCFA's proposed option of multiyear HMO contracts, though we do not support "discounting" payment rates under such contracts. In our view, multiyear contracts should not be used as a mechanism to obtain greater savings but rather to improve the stability of the HMO/CMP program.

Additional difficulties arise from the potential for rate reductions under the Gramm-Rudman law. In 1985 a one percent reduction in Medicare capitation payments occurred. A 1987 reduction was avoided based on an interpretation by HCFA that the Gramm-Rudman statute and legislative history indicated no congressional intent that the AAPCC would be subject to reduction. While the law provides that Gramm-Rudman reductions are not to be taken into account in calculating the AAPCC in subsequent years, it is silent regarding cuts in the current year's payment rate. This silence is in contrast to Gramm-Rudman's explicit provisions on payment cuts for individual fee-for-service benefits. We are concerned that the potential for future Gramm-Rudman cuts in HMO payments discourages greater participation by HMOs in Medicare risk contracting.

Congress should clarify that payments to risk-based HMOs/CMPs are not subject to any Gramm-Rudman reduction. This clarification is needed to assure that HCFA's interpretation of the law is not overturned unexpectedly. Exempting these payments would promote program stability and is justified because of the special nature of risk-based providers. Under risk-based contracts, the HMO/CMP must agree to provide services to all enrollees during the calendar year. In contrast, other providers may choose not to care for Medicare beneficiaries if they believe payment rates are inadequate after Gramm-Rudman reductions.

We believe adoption of the proposals we have outlined above would increase interest by HMOs and PPOs in Medicare contracts. It may also be appropriate to consider the introduction of HMO/CMP contracts that involve a sharing of the risk between the government and the prepaid entity. Such arrangements might include risk corridors using predetermined formulas for distributing financial risk and reward. These arrangements would attract more HMOs and CMPs to Medicare by reducing the risk associated with inaccuracies in the capitation payment formula. Risk-sharing still would provide significant efficiency incentives, as indicated by the experience of certain Medicaid capitation arrangements. We would urge that Congress encourage HCFA to conduct demonstrations of various risk-sharing approaches.

Physician Incentive Programs

Another major problem of Medicare capitation is the prohibition of physician incentive programs, which under current law would occur April 1, 1990. While we support this prohibition's delayed effective date set by OBRA-87, long-range planning continues to be virtually impossible because these incentive arrangements are an integral part of most HMO/CMP operations.

In the HMO setting, doctors affiliated with an HMO generally share the financial risk or reward resulting from the relative efficiency of the organization. These risks and rewards are structured on an individual or group basis, or some combination of both.

We agree that an incentive system based on the cost of treating an individual patient may create the potential for underprovision of care. But physician behavior is influenced by a number of factors, of which financial arrangements play only a partial role. Additional factors influencing physician behavior include professional (medical) standards, malpractice litigation, peer review, HMO quality assurance programs and on-going utilization review activities. Extreme caution must be used when attributing physician behavior to financial reimbursement arrangements alone. We would note that the potential for underprovision of care is reduced when a risk/reward system is based on the costs of an individual physician's overall caseload. In this situation, the cost of treating any one patient generally has only a minor effect on the overall relation between the physician's caseload capitation payments and the performance target for those patients.

We are concerned with one implication drawn by the recent congressionally-mandated physician incentive study done under contract to HHS. The study found that "only" 15 percent of sample HMOs/CMPs used arrangements based on payment rate and expense experience of individual affiliated physicians. The implication is that these individual arrangements could be prohibited, affecting only a few HMOs, while the bulk with aggregate (group) arrangements could be freed from the uncertainty of the prohibition.

Based on our experience, we believe the study's sample under-represented the prevalence of HMOs using arrangements linked to individual physician performance. For instance, 67 percent of Blue Cross and Blue Shield affiliated HMOs use this approach, in whole or in part. We would note that none of these arrangements involve financial incentives related to patient-specific performance criteria. We have attached a copy of our recent Plan HMO/CMP physician incentives survey which details the arrangements used by our affiliated HMOs and CMPs.

In our experience, physician incentive programs clearly have increased HMO efficiency. This increased efficiency has resulted in enhanced coverage for Medicare enrollees. We are not aware of any instances in which use of such incentives has reduced quality of care. We would urge Congress to take action as soon as possible to eliminate the uncertainty over what types of incentive arrangements are permissible for HMOs/CMPs. One alternate approach that should be considered would be to focus quality review at the individual physician level when incentive arrangements apply to individual physicians and focus such review on physician groups when aggregate incentives apply. This approach would avoid the inherent difficulty of defining in the law specific types of arrangements that threaten quality of care.

Summary

In conclusion, while we believe Medicare capitation offers the opportunity for both cost containment and enhanced coverage of beneficiaries, we urge you to correct the problems in the current HMO/CMP program. We recommend improving the AAPCC payment method and encouraging HMO/CMP efficiency incentives through use of appropriate physician incentive programs. We would be pleased to assist the subcommittee as you pursue these important topics.

A SURVEY OF
PHYSICIAN FINANCIAL PAYMENT ARRANGEMENTS
IN BLUE CROSS AND BLUE SHIELD PLAN HMOs

BY

BLUE CROSS AND BLUE SHIELD ASSOCIATION
CHICAGO, ILLINOIS
JANUARY, 1987

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I. BACKGROUND

GOVERNING LEGISLATION

- o IN ORDER TO ENHANCE EARNINGS UNDER THE MEDICARE HOSPITAL DRG REIMBURSEMENT PROGRAM, AT LEAST ONE HOSPITAL (PARACELSUS) IMPLEMENTED A PROGRAM OF FINANCIAL INCENTIVES TO SHARE REVENUE SAVINGS FROM EARLY DISCHARGES WITH THE ATTENDING PHYSICIAN(S). FINANCIAL COMPENSATION WAS DIRECTLY RELATED TO CASE ACTIONS - SHORT STAYS LEAD TO INCREASED PHYSICIAN COMPENSATION.

- o IN RESPONSE TO THIS ACTION, REPRESENTATIVE STARK INTRODUCED LEGISLATION (OBRA-86) WHICH MADE CERTAIN TYPES OF INCENTIVE PAYMENTS TO PHYSICIANS ILLEGAL. WHILE NOT THE PRIMARY INTENT OF THE LEGISLATION, IT NEVERTHELESS, PROHIBITED HMOS CONTRACTING WITH MEDICARE FROM ALSO EMPLOYING PHYSICIAN INCENTIVE ARRANGEMENTS TIED TO UTILIZATION TARGETS.

- o CONGRESS AND HCFA RECOGNIZED THAT EXCEPTIONS WOULD NEED TO BE MADE TO ACCOUNT FOR THE UNINTENDED IMPACT OF THIS LEGISLATION ON HMOs. HCFA WAS DIRECTED TO IDENTIFY SPECIFIC "EXCEPTIONS" FOR CONGRESSIONAL CONSIDERATION AND COMMISSIONED ICF, INC., AN INDEPENDENT RESEARCH FIRM, TO CONDUCT A STUDY OF CURRENT HMO PHYSICIAN INCENTIVE PAYMENT ARRANGEMENTS.

- o IN LIGHT OF THE ACKNOWLEDGED NEED FOR EXCEPTIONS, IMPLEMENTATION OF THE PHYSICIAN INCENTIVE PROHIBITION WAS SET FOR APRIL 1, 1989. HCFA RECOMMENDATIONS WERE TO BE PRESENTED TO CONGRESS IN JANUARY, 1988. (BUDGET RECONCILIATION LEGISLATION HAS SINCE EXTENDED THE EFFECTIVE DATE TO APRIL 1, 1990.)

BLUE CROSS AND BLUE SHIEILD PLAN CONCERNS

- o BLUE CROSS AND BLUE SHIELD PLAN HMOs ARE MAJOR PARTICIPANTS IN THE MEDICARE TEFRA PROGRAM. AS OF JUNE 1987, PLAN HMOs AND PPOs HELD 47 TEFRA RISK CONTRACTS WITH ENROLLMENT OF 154,444 MEDICARE MEMBERS. THIS REPRESENTED APPROXIMATELY 17% OR 1/6 OF ALL MEDICARE TEFRA PROGRAM ENROLLMENT. THE PHYSICIAN INCENTIVE PROHIBITION LEGISLATION COULD SIGNIFICANTLY IMPACT OUR ABILITY TO SERVE THESE MEMBERS.

- o MOREOVER, THE 107* BLUE CROSS AND BLUE SHIELD PLAN HMOs CURRENTLY OPERATING ACROSS THE NATION REPRESENT A MAJOR VEHICLE FOR EXPANDING THE TEFRA PROGRAM**. AT PRESENT (JUNE, 1987) ONLY 27 OF THESE HMOs PARTICIPATE IN THE MEDICARE TEFRA PROGRAM.

- o UPON NOTIFICATION OF PASSAGE OF THIS LEGISLATION, THE BLUE CROSS AND BLUE SHIELD ASSOCIATION CONDUCTED A SURVEY OF ITS MEMBER HMOs TO ASSESS THE POTENTIAL IMPACT OF THE BILL.

* For purposes of this study, we have treated stand-alone regional HMO programs in Florida and Massachusetts as separate HMOs even though they are legally part of combined holding company programs. As a result, our published June, 1987 Blue Cross and Blue Shield Plan HMO Activity Report lists fewer HMOs (only 94) than the 107 programs reported for this study.

** As of December, 1987, seven (7) Blue Cross and Blue Shield Plans dropped their MEDICARE TEFRA contracts, leaving a total of only 20 Plans participating in the program.

2. SURVEY APPROACH

APPROACH:

- THE PRIMARY DATA COLLECTION INSTRUMENT FOR THE SURVEY WAS A MAIL QUESTIONNAIRE TO BE COMPLETED BY PLAN HMOs. IN ORDER TO MAXIMIZE THE OVERALL USEFULNESS AND COMPARABILITY OF SURVEY RESULTS, WE ADOPTED THE GHAA SURVEY INSTRUMENT AND HAVE SHARED SUMMARY STATISTICS WITH GHAA.

- MAILED IN MARCH 1987, THE QUESTIONNAIRE WAS SUPPLEMENTED WITH FOLLOW-UP TELEPHONE CALLS IN JUNE AND JULY TO CLARIFY INDIVIDUAL SURVEY RESPONSES AND OBTAIN ADDITIONAL DATA WHERE NEEDED.

- ALTHOUGH RAW SURVEY RESPONSES WERE SHARED WITH GHAA, THE SURVEY RESULTS FOR PLAN HMOs WERE SEPARATELY ANALYZED BY THE BLUE CROSS AND BLUE SHIELD ASSOCIATION. OUR OBJECTIVES WERE TO:
  - DOCUMENT THE TYPES OF PHYSICIAN REIMBURSEMENT ARRANGEMENTS USED BY PLAN HMOs
  - ASSESS THE IMPACT OF CURRENT LEGISLATION (AND POSSIBLE EXCEPTIONS) ON EXISTING AND POTENTIAL MEDICARE TEFRA CONTRACTORS

SURVEY RESPONSE:

AT THE TIME OF THE SURVEY, THERE WERE 107 PLAN HMO PROGRAMS WITH A COMBINED ENROLLMENT OF 4.2 MILLION MEMBERS. THIS REPRESENTS A MARKET SHARE OF APPROXIMATELY 15% OF TOTAL HMO INDUSTRY ENROLLMENT.

A TOTAL OF 83 HMOs RESPONDED TO THE SURVEY. AS SHOWN IN EXHIBITS 1 and 2, THIS REPRESENTS 78% OF PLAN HMOs AND 78% OF SYSTEM WIDE ENROLLMENT (APPROXIMATELY 3.3 MILLION MEMBERS). IT INCLUDES ALL BUT 2 OF THE 27 BLUE CROSS AND BLUE SHIELD PLAN HMOs PARTICIPATING IN THE MEDICARE TEFRA PROGRAM.*

* We do not believe there is "reporting bias" in the case of the two Medicare TEFRA HMOs which failed to respond to the survey.

EXHIBIT 1

SURVEY RESPONSE RATE - ALL HMOs

Model Type	All Blue Cross and Blue Shield Plan HMOs		HMOs Responding to the Survey	
	Number*	Enrollment**	Number*	Enrollment**
Staff	11	438,189	8	402,542
Group	9	279,356	4	115,834
Group Network	4	292,826	4	180,507
IPA	60	1,496,952	50	1,488,712
Mixed Network	23	1,719,540	17	1,090,045
TOTALS	107	4,226,863	83	3,277,640
Percentage Responding				

*Regional components of HMOs that responded as distinct model types were reported separately for purposes of this survey.

**Enrollment as of June, 1987.

EXHIBIT 2

SURVEY RESPONSE RATE - PARTICIPATING TEFRA HMOs

Model Type	All Blue Cross and Blue Shield Plan HMOs With Medicare TEFRA Contracts			HMOs Responding to the Survey		
	Number	Contracts	Enrollment*	Number	Contracts	Enrollment*
Staff	4	5	12,884	4	5	12,884
Group	6	7	42,962	5	6	22,252
Group Network	—	—	—	—	—	—
IPA	11	21	50,948	10	20	46,422
Mixed Network	6	12	25,437	6	12	25,437
TOTALS	27	45	132,231	25	43	106,995

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*Enrollment as of June, 1987.

DATA LIMITATIONS

- o SURVEY FINDINGS ARE BASED ON SELF-REPORTED ANSWERS FROM PLAN HMOs. WHILE WE ATTEMPTED TO CLARIFY CERTAIN RESPONSES, THERE MAY STILL BE "DIFFERENCES OF INTERPRETATION" DUE TO THE PHRASING OF SELECTED QUESTIONS AND THE QUESTIONNAIRE DESIGN DEVELOPED BY GHAA AND USED FOR THIS STUDY.

- o AS IN THE GHAA STUDY, FOR THREE-TIERED ARRANGEMENTS (e.g., HMO CONTRACTS WITH PHYSICIAN ENTITY WHICH THEN CONTRACTS WITH INDIVIDUAL PHYSICIANS), THE PAYMENT ARRANGEMENTS BETWEEN THE PHYSICIAN ENTITY AND INDIVIDUAL PHYSICIANS MAY NOT BE FULLY REFLECTED.

- o THE QUESTIONNAIRE'S PRINCIPAL FOCUS IS ON THE FINANCIAL INCENTIVES USED BY HMOs FOR THEIR PRIMARY CARE PHYSICIANS. DIFFERENT PAYMENT ARRANGEMENTS ARE TYPICALLY USED FOR SPECIALTY CARE SERVICES. THESE ARRANGEMENTS, ON WHOLE, INCLUDE FEWER FINANCIAL INCENTIVE PROVISIONS THAN THOSE FOR PRIMARY CARE SERVICES.

- o THE QUESTIONNAIRE WAS DESIGNED BEFORE THE ICF TYPOLOGY (THE INDEPENDENT STUDY FINANCED BY HCFA) WAS DEVELOPED. AS A RESULT, IT IS NOT ALWAYS POSSIBLE TO DIRECTLY COMPARE THE RESPONSES TO OUR SURVEY WITH THEIR RESULTS.

- o MOST IMPORTANTLY, PHYSICIAN BEHAVIOR IS INFLUENCED BY A NUMBER OF FACTORS, OF WHICH FINANCIAL ARRANGEMENTS PLAY ONLY A PARTIAL ROLE. ADDITIONAL FACTORS INFLUENCING PHYSICIAN BEHAVIOR INCLUDE PROFESSIONAL (MEDICAL) STANDARDS, MALPRACTICE LITIGATION, PEER REVIEW, HMO QUALITY ASSURANCE PROGRAMS AND ON-GOING UTILIZATION REVIEW ACTIVITIES. EXTREME CAUTION MUST BE USED WHEN ATTRIBUTING PHYSICIAN BEHAVIOR TO FINANCIAL REIMBURSEMENT ARRANGEMENTS ALONE.

3. SURVEY FINDINGS

COMPONENTS OF AN HMO PHYSICIAN REIMBURSEMENT PROGRAM

HMO REIMBURSEMENT PROGRAMS TYPICALLY CONTAIN ALL OR SOME OF THE FOLLOWING COMPONENTS:

o BASE PAYMENT FOR SERVICES

- SALARY (TYPICALLY IN A STAFF MODEL)
- CAPITATION PAYMENT (FIXED PER MEMBER PER MONTH FEE) FOR SPECIFICED SERVICES TYPICALLY ADJUSTED TO REFLECT THE AGE/SEX MIX OF EACH PHYSICIAN'S HMO PATIENT LOAD
- FEE-FOR-SERVICE PAYMENT BASED ON EITHER A PERCENTAGE OF USUAL AND CUSTOMARY (U&C) CHARGES OR A NEGOTIATED FEE SCHEDULE

o WITHHOLD CONTINGENCY

- AN AMOUNT DEDUCTED FROM THE PHYSICIANS BASE PAYMENT AND "SET ASIDE" TO FINANCE HIGHER THAN EXPECTED HMO UTILIZATION. WITHHOLD CONTINGENCY FUNDS ARE ALWAYS RETURNED TO PHYSICIANS IF CONTRACTUAL TARGETS ARE ACHIEVED.
- WITHHOLD CONTINGENCY FUNDS REPRESENT NEGATIVE RISK SHARING WITH PARTICIPATING HMO PHYSICIANS. THEY DO NOT, BY THEMSELVES, REPRESENT A BONUS OR INCENTIVE FOR BELOW TARGETED UTILIZATION.
- WITHHOLD CONTINGENCIES TYPICALLY RANGE FROM 10% - 30% OF BASE PAYMENT AND CAN BE APPLIED TO BOTH PRIMARY CARE AND SPECIALTY CARE.

o INCENTIVE/SURPLUS SHARING (BONUS)

- INCENTIVE/SURPLUS SHARING (BONUS) ARRANGEMENTS REPRESENT A POSITIVE SHARING OF HMO PROFITS (SURPLUSES) WITH PARTICIPATING PHYSICIANS AND SOMETIMES PARTICIPATING HOSPITALS

o DISTRIBUTION ARRANGEMENTS

- DISTRIBUTION OF WITHHOLD AND INCENTIVE/SURPLUS PAYMENTS ARE USUALLY BASED ON A TWO STEP PROCESS: 1) ACHIEVEMENT OF OVERALL HMO PERFORMANCE TARGETS AND 2) ACHIEVEMENT OF INDIVIDUAL, GROUP UTILIZATION, OR COST TARGETS.

    . OVERALL PERFORMANCE TARGETS INCLUDE INPATIENT UTILIZATION RATES AND THE RATIO OF CERTAIN ACTUAL MEDICAL CARE EXPENSES TO BUDGET TARGETS. IF THESE PERFORMANCE TARGETS ARE MET, THE HMO WILL PROCEED WITH THE DISTRIBUTION PROCESS. IF THESE TARGETS ARE NOT MET, THERE MAY BE NO WITHHOLD OR INCENTIVE/SURPLUS SHARING PAYMENTS.

    . DISTRIBUTION OF WITHHOLD AND INCENTIVE/SURPLUS PAYMENTS ARE TYPICALLY BASED ON A PHYSICIAN'S INDIVIDUAL PERFORMANCE, THE PERFORMANCE OF A GROUP OF PHYSICIANS, THE HMO'S AGGREGATE PERFORMANCE OR SOME COMBINATION OF THESE APPROACHES.

o LOSS PROTECTION (STOP LOSS INSURANCE)

- TO PROTECT PHYSICIANS AGAINST CATASTROPHIC DOWN-SIDE RISK (FINANCIAL LOSSES), MANY HMOs EMPLOY A VARIETY OF RISK LIMITING (STOP LOSS) ARRANGEMENTS. THESE INCLUDE:
  - INDIVIDUAL CASE STOP-LOSS INSURANCE WHICH PROTECTS THE PHYSICIAN FROM COSTS INCURRED BY PATIENTS WHICH EXCEED A PREDETERMINED STOP-LOSS LIMIT (i.e., $10,000 OF PHYSICIAN SERVICES IN A PARTICULAR YEAR)
  - EXCLUSION OF CERTAIN HIGH COST CASES (i.e., OPEN HEART SURGERY) FROM PHYSICIAN RISK POOLS TO PREVENT OR REDUCE THE EFFECT OF ADVERSE SELECTION ON THE PHYSICIAN'S RISK.

INDIVIDUAL HMOs EMPLOY VARIOUS COMBINATIONS OF THESE REIMBURSEMENT COMPONENTS TO ESTABLISH A FINANCIAL REIMBURSEMENT PACKAGE WHICH IS ACCEPTABLE TO PHYSICIANS IN A PARTICULAR LOCALE. NEITHER THE PHYSICIAN NOR THE HMO WORKS IN A VACUUM - ALL ARRANGEMENTS REPRESENT A COMPROMISE OF CONFLICTING VIEWPOINTS AND OBJECTIVES - THOSE OF THE HMO AND THOSE OF THE PARTICIPATING PHYSICIAN AND LOCAL PHYSICIAN COMMUNITY.

SUBSEQUENT SECTIONS DESCRIBE HOW EACH OF THESE COMPONENTS IS USED BY THE 83 BLUE CROSS AND BLUE SHIELD PLAN HMOs RESPONDING TO THE PHYSICIAN FINANCIAL PAYMENT ARRANGEMENTS STUDY.

BASE PAYMENT FOR SERVICES

- AS SHOWN ON EXHIBIT 3, CAPITATION IS THE MOST PREVALENT FORM OF BASE PAYMENT FOR PRIMARY CARE SERVICES. IT IS ESPECIALLY PREVALENT IN NON-STAFF MODEL HMOs (65/75 = 87%). STAFF MODEL HMOs, IN CONTRAST, TYPICALLY RELY ON SALARY ARRANGEMENTS FOR PURCHASING PRIMARY CARE PHYSICIAN SERVICES.

- A VARIETY OF SERVICES CAN BE INCLUDED IN THE PRIMARY CARE PHYSICIAN CAPITATION. AS SHOWN IN EXHIBIT 4, THE MOST COMMON SERVICES INCLUDED IN THE CAPITATION AGREEMENT ARE:

- PRIMARY CARE OFFICE VISITS	98%
- PRIMARY CARE PHYSICIAN VISITS TO HOSPITALIZED PATIENTS	71%
- ROUTINE LAB AND X-RAY	63%

- AS SHOWN ON EXHIBIT 5, FEE-FOR-SERVICE PAYMENTS - EITHER ON A PERCENTAGE OF USUAL AND CUSTOMARY CHARGES BASIS OR A NEGOTIATED FEE SCHEDULE BASIS - ARE THE MOST PREVALENT FORM OF PAYMENT FOR SPECIALTY CARE. SPECIALTY PHYSICIANS' CAPITATION PAYMENTS OCCUR IN ONLY 22% OF THE HMOs SURVEYED AND ARE MOST FREQUENTLY SEEN IN HMOs THAT CONTRACT WITH "LARGE PHYSICIAN GROUP TYPE" PRACTICES.*

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* Some IPA arrangements allow physicians to form "voluntary provider groups" for capitation payment purposes.

EXHIBIT 3

NUMBER OF HMOs USING VARIOUS BASE PAYMENT ARRANGEMENTS FOR FINANCING PRIMARY CARE PHYSICIAN SERVICES

MODEL TYPE	SALARY	CAPITATION	FEE-FOR-SERVICE
Staff (8)	7	1	0
Group (4)	1	3	0
Group Network (4)	1	3	0
IPA (50)	1	42	7
Mixed Network (17)	0	16	1
TOTAL (83)	10	65	8
PERCENT	12%	78%	10%

*A total of 83 HMOs completed this portion of the survey.

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EXHIBIT 4

NUMBER OF HMOs INCLUDING SELECTED SERVICES IN THEIR PRIMARY CARE PHYSICIAN CAPITATION

MODEL	PRIMARY CARE OFFICE VISIT	PRIMARY CARE PHYSICIAN VISITS TO HOSPITALIZED PATIENTS	ROUTINE X-RAY AND LAB
Staff (1)	1	1	1
Group (3)	2	2	2
Group Network (3)	3	3	3
IPA (42)	42	24	21
Mixed Network (16)	16	16	14
TOTAL (65)	64	46	41
PERCENT OF TOTAL	98%	71%	63%

*A total of 65 HMOs completed this portion of the survey.

EXHIBIT 5

NUMBER OF HMOs USING VARIOUS BASE PAYMENT ARRANGEMENTS FOR FINANCING SPECIALTY CARE SERVICES

MODEL	NOT APPLICABLE - PCPs ARE CAPITATED FOR SPECIALTY SERVICES	FEE-FOR-SERVICE CHARGES	CAPITATION	SALARY
Staff (8)	—	2	2	4
Group (4)	—	2	2	--
Group Network (4)	2	—	1	1
IPA (50)	—	44	6	--
Mixed Network (17)	3	7	7	--
TOTAL (83)	5	55	18	5
PERCENTAGE	6%	66%	22%	6%

*A total of 83 HMOs completed this portion of the survey questionnaire.

WITHHOLD CONTINGENCY

- AS SHOWN ON EXHIBIT 6, THE MAJORITY (65%) OF PLAN HMOs EMPLOY SOME FORM OF WITHHOLD ARRANGEMENT WHICH PLACES PARTICIPATING PHYSICIANS "AT RISK" FOR MEMBER UTILIZATION.

- TYPICAL PRIMARY CARE PHYSICIAN WITHHOLD FACTORS RANGE BETWEEN 10%-30% OF BASE PAYMENTS WITH LITTLE VARIATION BY MODEL TYPE.

EXHIBIT 6

NUMBER OF HMOs EMPLOYING WITHHOLD ARRANGEMENTS FOR PRIMARY CARE PHYSICIAN SERVICES

MODEL	WITHHOLD	WITHHOLD AND BONUS	TOTAL NUMBER	TOTAL PERCENTAGE	RANGE OF PCP WITHHOLD
Staff (4)	—	—	—	—	N/A
Group (2)	—	2	2	100%	15%-25%
Group Network (1)	—	—	—	—	N/A
IPA (48)	30	5	35	72.9%	10%-30%
Mixed Network (17)	5	6	11	64.7%	10%-20%
TOTAL (74)	35	13	48		
PERCENTAGE	47%	18%	65%		

*A total of 74 HMOs completed this portion of the survey questionnaire.

INCENTIVE/SURPLUS SHARING

o AS SHOWN IN EXHIBIT 7, MORE THAN HALF (54%) OF THE SURVEYED HMOs REPORTED TO HAVE EMPLOYED INCENTIVE/SURPLUS SHARING ARRANGEMENTS THROUGH WHICH PARTICIPATING PHYSICIANS SHARE IN THE ORGANIZATION'S FINANCIAL SUCCESS.

o INCENTIVE/SURPLUS SHARING ARRANGEMENTS INCLUDED BONUS ONLY AND BONUS/WITHHOLD ARRANGEMENTS.

- BONUS ONLY: UNDER THESE ARRANGEMENTS, PHYSICIANS SHARE HMO SURPLUSES AND ARE NOT AT RISK FOR HMO DEFICITS.

- BONUS/WITHHOLD: UNDER THIS ARRANGEMENT, PHYSICIANS SHARE HMO SURPLUSES BUT ARE ALSO AT RISK FOR HMO DEFICITS UP TO THE WITHHOLD AMOUNT.

EXHIBIT 7

NUMBER OF HMOs WITH VARIOUS INCENTIVE/SURPLUS SHARING ARRANGEMENTS

MODEL	BONUS ALONE	BONUS COMBINED WITH WITHHOLD**	TOTAL NUMBER	TOTAL PERCENTAGE
STAFF (4)	3	—	3	75%
GROUP (2)	—	2	2	100%
GROUP NETWORK (1)	1	—	1	100%
IPA (48)	13	11	24	50%
MIXED NETWORK (17)	3	6	9	53%
TOTAL (72)	20	19	39	
PERCENTAGE	27.8%	26.4%	54.2%	

* A total of 72 HMOs responded to this question.

** The reported number of HMOs employing bonus combined with withhold arrangements differs from that in Exhibit 6, since this table includes financial arrangements for both primary and specialty care.

DISTRIBUTION ARRANGEMENTS

- TWO PRINCIPAL FACTORS ARE TYPICALLY CONSIDERED IN THE DISTRIBUTION OF WITHHOLD CONTINGENCY AND INCENTIVE/SURPLUS SHARING FUNDS - CONTRACTUAL PAYMENT REQUIREMENTS (PERFORMANCE INDICATORS) AND THE MANNER IN WHICH FUNDS ARE ALLOCATED AMONG ELIGIBLE PHYSICIANS.

- EXHIBIT 8 SHOWS THE MOST COMMON PERFORMANCE MEASURES USED TO DETERMINE WHEN PRIMARY CARE PHYSICIAN WITHHOLD AND INCENTIVE SURPLUS SHARING PAYMENTS WILL BE MADE. AS SHOWN, THE RATIO OF ACTUAL UTILIZATION TO TARGETED UTILIZATION, AND SURPLUS IN DESIGNATED REFERRAL FUND ARE THE TWO MOST COMMON PERFORMANCE MEASURES USED BY BLUE CROSS AND BLUE SHIELD PLAN HMOs.

- TYPICAL APPROACHES TO THE MANNER OF DISTRIBUTION OF WITHHOLD CONTINGENCY AND INCENTIVE/SURPLUS FUNDS INCLUDE:

  - GROUP SHARING: ALL PHYSICIANS RECEIVE THEIR WITHHOLDS AND/OR AN EQUAL (TYPICALLY A PERCENTAGE) SHARE OF HMO INCENTIVE/SURPLUS FUNDS BASED ON THEIR RESPECTIVE PATIENT LOADS OR VOLUME OF FEE-FOR-SERVICE CHARGES.

  - INDIVIDUAL COMPENSATION: PHYSICIANS WHO MEET THEIR INDIVIDUAL UTILIZATION TARGETS RECEIVE THEIR INDIVIDUAL WITHHOLD AND/OR AN INCENTIVE PAYMENT.

  - COMBINATION GROUP/INDIVIDUAL DISTRIBUTION: PHYSICIANS WHO MEET THEIR INDIVIDUAL UTILIZATION TARGETS RECEIVE BACK THEIR OWN WITHHOLD AND QUALIFY TO PARTICIPATE IN GROUP BASED SURPLUS SHARING. PHYSICIANS FAILING TO MEET THEIR INDIVIDUAL UTILIZATION TARGETS DO NOT QUALIFY FOR INCLUSION IN THE SURPLUS SHARING.

- AS SHOWN IN EXHIBIT 9, COMBINED GROUP/INDIVIDUAL DISTRIBUTION (57%) IS THE MOST PREVALENT ARRANGEMENT FOR PAYING OUT WITHHOLD AND INCENTIVE/SURPLUS FUNDS.

EXHIBIT 8

NUMBER OF HMOs EMPLOYING VARIOUS PERFORMANCE MEASURES FOR DETERMINING IF PRIMARY CARE WITHHOLD AND SURPLUS/INCENTIVE PAYMENT WILL BE MADE

MODEL	RATIO OF ACTUAL HMO COSTS TO BUDGET*	RATIO OF ACTUAL INPATIENT OR REFERRAL COSTS TO BUDGET*	ACTUAL UTILIZATION COSTS TO TARGET*	SURPLUS IN DESIGNATED REFERRAL FUND**	OTHER ARRANGEMENTS
Staff (2)					2
Group (2)		2			
Group Network					
IPA (43)	3	2	16	19	3
Mixed Network (10)	1	—	5	3	1
TOTAL (57***)	4	4	21	22	6
PERCENT	7%	7%	37%	39%	10%

*13 or 23% of the 29 HMOs which use ratios of total HMO costs to budget, inpatient utilization to targets, or inpatient and referral costs to budget applied these performance measures in combination with the requirement that there be a surplus remaining in the primary care referral fund.

**39% of HMOs use surplus in designated fund as their sole performance measurement.

***A total of 57 HMOs reported using various performance measures for determining when withhold and incentive/surplus sharing payments to primary care physicians will be made.

EXHIBIT 9

NUMBER OF HMOs EMPLOYING VARIOUS BASES FOR DISTRIBUTION OF WITHHOLD CONTINGENCY AND INCENTIVE/SURPLUS FUNDS

MODEL	GROUP PERFORMANCE	INDIVIDUAL PERFORMANCE	COMBINATION INDIVIDUAL GROUP PERFORMANCE
STAFF (1)	—	1	—
GROUP (2)	1	—	1
GROUP NETWORK (1)	1	—	1
IPA (40)	14	5	21
MIXED NETWORK (16)	4	—	12
TOTAL (61)	20	6	35
PERCENTAGE	32.8%	9.8%	57.4%

*A total of 61 HMOs responded to this question.

LOSS PROTECTION (STOP LOSS INSURANCE)

- o THE MAJORITY (92%) OF HMOs RESPONDING TO THIS QUESTION PROVIDED INDIVIDUAL STOP LOSS PROTECTION TO LIMIT A PHYSICIAN'S RISK FOR THE PROVISION OF CATASTROPHIC CARE (SEE EXHIBIT 10).

- o A NUMBER (15%) OF HMOs ALSO REPORTED EMPLOYING PROVISIONS FOR AUTOMATICALLY EXCLUDING CERTAIN TYPES OF HIGH RISK PATIENTS FROM A PHYSICIAN'S "RISK POOL." THESE ARRANGEMENTS ARE TYPICALLY USED IN ADDITION TO STOP LOSS PROTECTION.

EXHIBIT 10

NUMBER OF HMOs EMPLOYING VARIOUS STOP LOSS PROVISIONS

	INDIVIDUAL (PER CASE) STOP LOSS PROTECTION	EXCLUSION OF CERTAIN PATIENTS FROM RISK POOL
Staff (5)	5	2
Group (4)	3	—
Group Network (3)	3	—
IPA (44)	39	7
Mixed Network (16)	16	2
TOTAL (72)	66	11
PERCENTAGE	92%	15%

*A total of 72 HMOs responded to this question.

4. OBSERVATIONS AND CONCLUSIONS

GENERAL OBSERVATIONS

o THE MAJORITY OF PLAN HMOs (78%) USE CAPITATION AS THE PRINCIPAL PAYMENT ARRANGEMENT FOR FINANCING PRIMARY CARE SERVICES. THE CAPITATION ARRANGEMENT IS GENERALLY ACCOMPANIED BY

- WITHHOLD RISK SHARING	52%
- INCENTIVE/SURPLUS SHARING	53%
- LOSS PROTECTION	97%

o FEE-FOR-SERVICE CHARGES ARE THE MOST PREVALENT FORM OF PAYMENT FOR HMO SPECIALTY CARE SERVICES (66%). THIS MEANS THAT THE MAJORITY OF HMO SPECIALISTS ARE NOT AT RISK UNDER CAPITATION SYSTEMS ALTHOUGH THEY MAY PARTICIPATE IN WITHHOLD AND BONUS ARRANGEMENTS. SINCE MOST PRIMARY CARE PHYSICIAN (PCP) RISK IS LIMITED TO THE EXTENT OF THEIR WITHHOLD AGREEMENT, FINANCIAL RISK FOR THESE SERVICES IS, IN PRACTICE, RELATIVELY SMALL.

o IN ORDER TO LINK COMPENSATION TO PHYSICIAN PERFORMANCE IN A MEANINGFUL MANNER, 67% OF PLAN HMOs DISTRIBUTE WITHHOLD AND/OR INCENTIVE/SURPLUS SHARING PAYMENTS ON THE BASIS OF EACH PROVIDER'S INDIVIDUAL PERFORMANCE. THE MAJORITY (85%) OF THESE HMOs TIE THEIR INCENTIVE/SURPLUS PAYMENTS TO OVERALL HMO PERFORMANCE. THERE IS NO GUARANTEED INCENTIVE/SURPLUS SHARING TIED TO INDIVIDUAL PERFORMANCE IN THESE SITUATIONS.

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* 97% of HMOs with capitation arrangements had some form of loss protection.

- INDIVIDUAL PERFORMANCE BASED WITHHOLD AND INCENTIVE/SURPLUS ARRANGEMENTS ARE MOST FREQUENTLY EMPLOYED IN IPA AND MIXED NETWORK HMOs. STAFF AND GROUP MODEL PROGRAMS TEND TO USE OTHER TYPES OF FINANCIAL INCENTIVES (i.e., BONUS ONLY ARRANGEMENTS).

- MOST PROGRAMS (92%) HAVE SOME FORM OF LOSS PROTECTION FOR PARTICIPATING PHYSICIANS WHICH LIMITS THEIR FINANCIAL EXPOSURE FOR CATASTROPHIC CASES.

IMPACT ON CURRENT MEDICARE CONTRACTORS

- AS SHOWN IN EXHIBIT 11, UNDER CURRENT LEGISLATION VIRTUALLY ALL BLUE CROSS AND BLUE SHIELD PLAN HMO MEDICARE TEFRA CONTRACTORS WOULD BE IMPACTED BY THE PROPOSED LEGISLATION. THE FOLLOWING EXCEPTIONS WOULD SIGNIFICANTLY REDUCE THIS IMPACT:
  - "EXCEPTING" GROUP BASED INCENTIVE/SURPLUS SHARING ARRANGEMENTS WILL REDUCE THE IMPACT TO 56% OF PARTICIPATING HMOs AND 31% OF PARTICIPATING MEDICARE TEFRA ENROLLMENT.
  - "EXCEPTING" COMBINED GROUP/INDIVIDUAL INCENTIVE/SURPLUS SHARING ARRANGEMENTS WILL REDUCE THE IMPACT TO 12% OF PARTICIPATING HMOs AND 2% OF PARTICIPATING MEDICARE TEFRA ENROLLMENT.
- AS SHOWN IN EXHIBIT 12, THE IMPACT ON PLAN HMOs WHICH MIGHT POTENTIALLY PARTICIPATE IN THE MEDICARE TEFRA PROGRAM IS EVEN LARGER THAN THE IMPACT ON EXISTING PROGRAMS.

EXHIBIT 11

IMPACT OF CURRENT LEGISLATION AND POTENTIAL EXCLUSIONS ON PLAN HMOs WITH MEDICARE TEFRA CONTRACTS

	NUMBER OF HMOs IMPACTED	PERCENT OF HMOs IMPACTED	MEDICARE TEFRA ENROLLMENT IMPACTED	
Current Legislation (Prohibiting all Types of Physician Incentives)	21	84%	68,067	(64%)
Exclusion of Group Based Incentive/ Surplus Sharing Arrangements	14	56%	33,517	(31%)
Exclusion of Combined Individual/ Group Based Incentive Surplus Sharing Arrangements	3	12%	1,557	(2%)

*Based on a survey sample of 25 Plan HMOs with Medicare TEFRA Contracts enrolling 106,995 members as of June, 1987.

EXHIBIT 12

IMPACT OF CURRENT LEGISLATION AND POTENTIAL EXCLUSIONS ON ALL PLAN HMOs

	NUMBER OF HMOs IMPACTED	PERCENT OF HMOs IMPACTED
Current Legislation (Prohibiting all Types of Physician Incentives)	72	87%
Exclusion of Group Based Incentive/ Surplus Sharing Arrangements	52	63%
Exclusion of Combined Individual/ Group Based Incentive Surplus Sharing Arrangements	17	20%

*Based on a survey sample of 83 reporting HMOs.

COMPARISONS WITH ICF AND GHAA FINDINGS

COMPARISIONS AMONG THE THREE STUDIES (BCBSA, GHAA AND ICF) MUST BE MADE WITH GREAT CARE. ALTHOUGH WE USED GHAA's SURVEY QUESTIONNAIRE, SEPARATE ANALYSES WERE PERFORMED. MOREOVER, THE ICF TYPOLOGY WAS NOT AVAILABLE WHEN THE GHAA QUESTIONNAIRE WAS DEVELOPED, SO ICF DATA ARE NOT NECESSARILY COMPARABLE. NEVERTHELESS, THERE ARE FOUR AREAS WHERE COMPARISONS AMONG THE STUDIES MIGHT BE MADE WITH CAUTION. EXPLAINED BELOW, THESE ARE:

- PREVALENCE OF HMO MODEL TYPE
- FREQUENCY OF CAPITATION ARRANGEMENTS
- FREQUENCY OF WITHHOLD AND INCENTIVE/SURPLUS (BONUS) SHARING ARRANGEMENTS
- DISTRIBUTION ARRANGEMENTS FOR FUNDS

o PREVALENCE OF HMO MODEL TYPE

- AS SHOWN IN EXHIBIT 13, IPA AND MIXED NETWORK MODEL HMOs REPRESENTED A SIGNIFICANTLY GREATER PROPORTION (81%) OF OUR SURVEY SAMPLE THAN GHAA's SAMPLE (58%), REFLECTING THE MAKE-UP OF THE TWO ORGANIZATIONS' MEMBER PROGRAMS. HENCE, A GREATER PROPORTION OF OUR RESULTS ARE BASED ON HMOs THAT CONTRACT DIRECTLY WITH INDIVIDUAL PHYSICIANS. NATIONALLY, IPA MODELS ACCOUNT FOR NEARLY TWO-THIRDS OF ALL HMO PROGRAMS. THE PRELIMINARY ICF REPORT DID NOT PROVIDE A BREAKOUT OF HMO MODELS FOR COMPARISON PURPOSES.

SUBMISSION OF FHP, INC.

FHP, Inc. appreciates the opportunity to submit comments to the Health Subcommittee on Medicare capitation programs and commends the Chairman and the members of the Subcommittee for their long-standing support of programs which provide a quality alternative to the fee-for-service Medicare system.

THE FHP PROGRAM - SENIOR PLAN

FHP, Inc. (the Company) currently has the fourth largest aggregated Medicare enrollment of the 134 Medicare TEFRA contractors. The Company has the largest enrollment of the 13 Medicare contractors in California, Arizona, and New Mexico. In 1983, FHP started Senior Plan, the first capitated Medicare program in California and has since expanded its Medicare program into Arizona and New Mexico. Including its other prepaid health programs in Utah and the South Pacific, the corporation's total national enrollment exceeds 385,000. Over 96,000 of the members are over the age of 65 and participate in FHP's Senior Plan.

FHP is one of only 15 Medicare contractors which do not charge enrollees a premium for the program. Senior Plan copays for services are minimal, covering drugs as a basic plan benefit. In California, for example, Senior Plan offers the following to Medicare eligibles:

Benefit	Copay
Outpatient Care	$5 per visit
Prescription Drugs	$3 per prescription visit unit
Hospital Care	No charge-up to 90 days per illness
Skilled Nursing	No charge
Home Health Care	No charge
Emergency Care	No charge
Routine Physicals	$5 per visit

FHP Senior Plan provides more care than Medicare at a cost savings to beneficiaries. There are other savings as well: FHP estimates that during 1987 alone, the Company saved the federal government approximately $15 million by serving Medicare members for a fixed monthly fee.

The most critical component of FHP's Senior Plan is quality assurance. Careful and intensive screening of every potential FHP physician is conducted with subsequent and frequent internal peer review is an ongoing process. Physicians and staff are trained to meet the special health care needs of Seniors. Medical centers are specifically designed for seniors with easy access, wider corridors, and larger pharmacies. In two areas FHP has recently qualified for limited PRO/QRO review, a further illustration of the quality of FHP's Senior Plan. (Limited review status is granted those plans whose quality assurance programs meet the standard for the lowest level of PRO review.)

THE MEDICARE PROGRAM

As with any new or relatively new program, the Medicare TEFRA contracting system has experienced some serious growing pains and policy or procedural mistakes have extracted a cost not only in the public level of confidence but also in the level of participation by the HMO/CMP industry. While FHP shares a common

view with many in the industry that progress has been made by HCFA in dealing with these problems, there are still serious issues which must be addressed in order to assure the continued viability of the program. These comments will concentrate on five issue areas: the current application of the 50/50 rule; Medicare reimbursement; the government as a business partner; implementation of the PRO program; and the need for further benefit flexibility.

THE 50/50 RULE - TIME TO REASSESS

As the members of the Subcommittee know, the 50/50 rule stipulates that a risk contractor must limit the plan's Medicare and Medicaid enrollment to no more than 50 percent of its total enrollment. The rule was originally conceived as an indirect proxy for quality assurance: if an HMO could maintain a 50 percent commercial enrollment base, it was assumed that sufficient quality of care was being provided to all the plan's members. Without the rule, legislators feared that a two-tiered health care system would exist: the first, an adequate plan for employer accounts and a second, separate system for older members which would not be adequate. FHP is concerned with the rigid application of the 50/50 rule, the current interpretation of which is preventing more beneficiaries from obtaining quality health care from experienced, well run Medicare programs.

FHP believes that in retrospect, the 50/50 rule is not as useful an indicator of quality of care as it once might have been. As currently implemented, the rule inhibits the development of well-managed plans which have made great strides in designing programs to meet the unique health care needs of this country's aging population. A far better guarantor of quality is the PRO/QRO review of HMO/CMP contractors, currently being implemented.

FHP respectfully urges the Subcommittee to consider a more realistic system of quality assurance than the 50/50 rule as presently interpreted by HCFA. For example, the law could be amended to permit multi-state HMOs, as long as they are meeting or exceeding PRO/QRO review criteria, to adjust their local or regional enrollment mix. As long as the plan's Medicare/Medicaid enrollment does not exceed 50 percent nationally the Medicare enrollment within separate areas could flex upward to meet the needs of more Medicare beneficiaries. In order to qualify for this flexibility, an entity would also be required to show several years of successful commercial and Medicare operational successes as well as a demonstrated track record of financial soundness. This option retains the overall 50/50 rule concept while simultaneously providing the much needed flexibility geographically diverse plans need to meet the local demands for well-designed, quality Medicare programs.

AAPCC - REIMBURSEMENT

Another area of critical concern to FHP is the adequacy of the AAPCC as an appropriate reimbursement formula. It is imperative that members of the Subcommittee understand that the data base does not always reimburse plans in a fair and equitable manner. This issue is the core from which all disaffections with HCFA contracts appear to emanate. The following, based on FHP experiences, illustrates the multifaceted nature of this problem:

- Average reimbursement rate is lower than 95 percent. As recently as January, a senior HCFA official noted in a public speech that the average reimbursement rate for plans was closer to 91 percent, based on his discussions with plans and industry experts. Considering that the AAPCC is clearly meant to be an average and that a plan's actual reimbursement is based on 120 demographic (age, sex, institutional statute, etc.) calculations, several factors combine to erode the reimbursement level when compared to a plan's true risk-based experience.

First, the rates are calculated on data that are 3 to 8 years old, averaged over a five-year time frame. In some areas, FHP suspects that the most significant cost increases in provider services have occurred in the last three years--cost data which has not been captured in the rate calculation. In some geographic areas, an HMO's reimbursement will not adequately reflect the actual current costs of providing hospital and physician services no matter how well or efficiently the plan manages its health care system. FHP recommends that the rates include an adequate update factor which reflects current cost experience.

Second, the geographic disparity in payment rates for adjoining counties inhibits natural plan expansion. Some of these geographic anomalies defy rational explanation. For example, in New Mexico, FHP's Medicare operations are centered in Albuquerque (Bernallio County). The average rate per enrollee in the county is $198.80. In Valencia county, which borders the city to the south, the average rate is $172.06 even though county residents have to seek medical care in Albuquerque.

Third, areas with the same or similar costs of living and of health care over the same time frame have vastly different reimbursement rates. Data from the Association of Local Chambers of Commerce shows that the cost of health care in Phoenix, Arizona (100 percent representing the national average) is 128.9 percent, compared to that of 131.5 percent for health care in Los Angeles county in California. Although there is only a 2.6 percent differential in comparative costs between Los Angeles County and Maricopa County (Phoenix, AZ), the reimbursement differential is an astounding 40 percent. It is FHP's view that the AAPCC in some of these areas is artificially low because many of the beneficiaries could not afford to access the health care system until FHP and other TEFRA contracts started their Medicare plans. In other words, the Medicare fee-for-service deductibles and copays were beyond the means of most of the population. As a result, they never entered the system, and Medicare never captured any cost data related to their health status. When these people enter the plan there is literally a "pent-up" need for a higher than expected level of health care. This "unmet need" is a serious issue and there is a need to consider the health status not only of this ghost population but also of people who defer treatment until acutely ill.

Fourth, Medicare costs in some areas do not reflect the percentage of physicians who accept or decline Medicare assignment or the market penetration of HMOs. In areas where only a small portion of the physicians accept assignment, it is difficult to recruit or retain physicians if the AAPCC is quantifiably lower than that which a physician might believe to be an "appropriate" fee. Again, the AAPCC data base does not capture amounts that non-assignment physicians bill patients in excess of the Medicare reimbursement amount. In areas where there is a high concentration of HMOs, the average cost data used to calculate the rates is also unfairly skewed and insensitive to actual costs of delivering health care in those markets.

Finally, HCFA imposes a small "handling fee" on the TEFRA contractors. HCFA extracts a set percentage from each monthly payment sent to the program's contractors. This presumably covers administrative costs, but in reality is a further erosion of the plans' rates.

THE GOVERNMENT AS A BUSINESS PARTNER

Coupled with FHP's concerns with the reliability and predictability of the AAPCC's, is our concern with the ever present specter of new mid-contract payment cuts. The managed-care system of health care delivery requires that contractors make extended commitments to provide a minimum package of benefits for a predetermined monthly rate. It is absolutely essential that the revenue base for the Medicare program is reliable and predictable. Mid-contract, budget-driven cuts not only erode plans' financial base but also undermine contract provider confidence in the program, and sometimes cause significant uncertainty in the Medicare beneficiary community.

Over the last three years, the Medicare rates have changed, at minimum, six or seven times. This includes HCFA modifications to the rates, Gramm-Rudman cuts and the annual rate changes. Each contract cycle, FHP negotiates and renews hundreds of provider contracts for both physician and hospital services. Provider payments are based on the Medicare-payment rates. Mid-contract reductions in those payments make it very difficult to retain provider confidence in the viability of Medicare risk contracts.

Further, there is little or no leeway for a plan to adjust the level of supplemental benefits offered to enrollees in response to payment cuts. Plans have contracted with the beneficiaries to provide a certain level of benefits and to suddenly change in mid-year is very disconcerting to seniors. These changes also give ammunition to those critics which delight in expounding on the flaws of pre-paid health care.

FHP encourages Congress to consider exempting Medicare contractors from future mid-contract rate cuts. If plans are required, as with non-governmental contract obligations, to uphold their contractual agreement with their members and providers of care, then the Federal government should be obligated to uphold its contractual agreement with the Medicare plans.

There are additional questions of contract equity to be considered by the Subcommittee. For example, every month FHP submits enrollment and disenrollment information on new Medicare members to HCFA and every month, despite the accuracy of the submissions, a number of of these actions are disallowed; not because the enrollee is not qualified, or because the data is incorrect, but only because HCFA has for various reasons frozen those individuals' files. (Usually HCFA is making file or clerical changes.) The problem for FHP is that we have represented to those new members that they are enrolled as of the first of the next month or have told current members that they are disenrolled. FHP generally honors those commitments even if the data has to be resubmitted, and therefore is not officially effective until a later month.

If a member goes elsewhere for care, in the belief they are no longer a member, FHP is liable for the bills. In these cases, HCFA does not retroactively accrete or delete members whose effective date was delayed by HCFA's own actions. Therefore, FHP is never paid for providing care for the first or last month enrollment period.

In addition, HCFA can retroactively adjust payments over the course of several years, and contractors cannot seek similar remedies or concessions from HCFA. Two examples:

- HCFA recently retroactively disenrolled two FHP members back to January 1985. (A three-year adjustment.) However, FHP does not have a similar ability to retroactively seek claims adjustments after twelve months.

- Changes in members' institutionalized status are difficult to track. Though plans are entitled to a higher rate for those individuals, if FHP does not receive notice from our providers within 60 days, FHP cannot receive the appropriate rate adjustment from HCFA. Plans should have a reasonable amount of time to submit information or member status.

Retroactive adjustments of months or years stemming from HCFA error have caused serious problems. FHP has recently received the final reconciliation for the 1983-1985 contract years. This adjustment contains no audit trail or documentation that the adjustment is correct. HCFA has informed FHP that the final reconciliation for 1987 may not occur for months. This is disconcerting given the fact that one preliminary reconciliation caused by a year-old HCFA clerical error cost FHP thousands of dollars.

The Company's problem with these adjustments is that they occur months and years after books have been closed and providers have been paid. In any business relationship there occurs the normal course of business adjustments to accounts to make certain only the amount to which the firm is entitled to by contract is paid, however reconciliations and adjustments by HCFA have not been made within an appropriate time frame. For now, HCFA can go back several years and withhold funds which a plan has already paid out in good faith to its providers. It is difficult and unfair to return to a hospital after one year and to request a $60,000 adjustment due to a HCFA clerical error.

FHP would encourage the Subcommittee to consider a statute of limitations on reconciliations.

PRO/QROs

FHP has long recognized that a key component of its long-standing success as an HMO has been its commitment to quality of care. FHP, like its industry counterparts, has expended a great deal of time in cooperative efforts to resolve as many of the administrative and start-up problems with the PROs' newly implemented HMO/CMP scope of work.

While FHP recognizes the need for external oversight of quality and feels that such reviews will confirm FHP's ability to provide quality of care, there are nevertheless areas of concern which have come to light during this initial "shake-down" period. These concerns are being shared with the Subcommittee in the hope that further understanding of the issues will enhance the review effort and, more importantly, the overall quality of health care available to Medicare beneficiaries.

In defense of the PRO/QRO contractors, the initial request for data was made on a very tight, contract-driven deadline. The request covered several months worth of retroactive reviews and hindered both the PROs/QROs' and the plans' ability to review and assemble the information in a timely manner. FHP was forced, as were other plans, to divert quality assurance personnel from their normal responsibilities to focus their efforts on assembling thousands of pages of data. This is a very costly and complex effort which might have been better organized and implemented if the PRO's contract with HCFA had been reasonably flexible on deadlines.

Since the reviews are a labor intensive process, there are very high cost factors involved. FHP, unlike many smaller contractors, does have reasonable computer capability. Even so, we calculate that plan-wide copying costs alone have totalled $15,000 per month since the start-up of the program. We

anticipate that the PRO will ask to review approximately 300 charts per month. Monitoring quality, protecting patient confidentiality, and collating information from geographically diverse health care providers is a very complex and intensive task. FHP would respectfully submit that there is a better way to integrate many of the best elements of HMOs' existing QA systems with the QA goals mandated by Congress when the PRO concept was expanded to include TEFRA contractors.

OTHER ISSUES

In looking to the future needs of our nation's aging population and the Company Senior members, FHP is assessing the needs of the frail elderly and ways to respond to the special care problems they face. If the AAPCC rate cells were expanded or refined to respond to some of the sub-acute care needs of these individuals, plans could offer adult day care, home-maker assistance, and meal services as cost effective alternatives to nursing home or acute care facilities.

FHP thanks the Subcommittee for their consideration of these comments and hopes that they are considered in the constructive manner in which they were intended If the Members or their staff have any questions or comments, we will be happy to respond.

- FREQUENCY OF CAPITATION ARRANGEMENTS

  - OUR DATA AND GHAA's SHOWED A SIMILARITY IN THIS CATEGORY WITH 78% OF BLUE CROSS AND BLUE SHIELD PLAN HMOs AND 75% OF GHAA MEMBER PLANS PAYING CAPITATION TO PRIMARY CARE PHYSICIANS. ICF DID NOT PROVIDE THIS DATA.

- FREQUENCY OF WITHHOLD AND INCENTIVE/SURPLUS (BONUS) SHARING ARRANGEMENTS

  - THE FREQUENCY OF WITHHOLDS AND INCENTIVE/SURPLUS SHARING ARRANGEMENTS VARIES CONSIDERABLY AMONG THE THREE STUDIES. OUR STUDY FOUND A HIGHER PERCENTAGE OF HMOs EMPLOYING WITHHOLDS ALONE (48.6%) THAN EITHER GHAA (21.9%) OR ICF (22.3%). IN ADDITION, ICF FOUND MORE PROGRAMS USING A COMBINATION OF WITHHOLD/BONUS (40.6%) THAN EITHER GHAA (16.5%) OR BCBSA (26.4%). THIS MAY INDICATE A NEED FOR BETTER CLARIFICATION OF SURVEY QUESTIONS/RESPONSES.

- DISTRIBUTION OF WITHHOLD/BONUS FUNDS ON THE BASIS OF INDIVIDUAL PHYSICIAN PERFORMANCE

  - AGAIN, THERE IS A MARKED DIFFERENCE IN FINDINGS. WHILE THE ICF STUDY REVEALED ONLY 15.1% OF HMOs USE INDIVIDUAL PERFORMANCE AS A BASIS FOR DISTRIBUTING WITHHOLD/BONUS FUNDS, THE BCBSA AND GHAA STUDIES FOUND 67.2% AND 61.2% RESPECTIVELY. THIS IS A CRITICAL DIFFERENCE IF INDIVIDUAL VERSUS GROUP DISTRIBUTION ARRANGEMENTS ARE CONSIDERED IN DRAFTING EXCEPTIONS TO THE OBRA PROVISION.

EXHIBIT 13

COMPARISONS AMONG BCBSA, GHAA AND ICF STUDIES OF PHYSICIAN FINANCIAL PAYMENT ARRANGEMENTS

	PERCENTAGE OF IPA/MIXED NETWORK HMOs	FREQUENCY OF CAPITATION ARRANGEMENTS	PRESENCE OF WITHHOLD CONTINGENCY FUND ONLY**	PRESENCE OF INCENTIVE/SURPLUS (BONUS) FUND	PRESENCE OF BOTH WITHHOLD & INCENTIVE/ SURPLUS FUNDS	DISTRIBUTION OF FUNDS ON THE BASIS OF INDIVIDUAL PERFORMANCE
BCBSA*	81%	78%	48.6%	27.8%	26.4%	67.2%
GHAA*	58%	75%	21.9%	25.6%	16.5%	61.2%
ICF*	N/A	N/A	22.3%	25.5%	40.6%	15.1%

* BCBSA sample of 83 HMOs
GHAA sample of 164 HMOs
ICF Sample of 145 TEFRA HMOs plus 20 percent of non-TEFRA programs

** Reported statistics relate to the provision of primary care physician (PCP) services only.

AREAS FOR FURTHER STUDY

THE THREE STUDIES OF PHYSICIAN FINANCING ARRANGEMENTS COMPLETED TO DATE - ICF, GHAA AND BCBSA - RAISE QUESTIONS WHICH SHOULD BE FURTHER PURSUED.

- WHY DO BCBSA, GHAA AND ICF FINDINGS ON THE FREQUENCY AND METHOD OF DISTRIBUTION OF WITHHOLD AND INCENTIVE/SURPLUS SHARING ARRANGEMENTS DIFFER SO MUCH?
- WHAT IS A PHYSICIAN'S MAXIMUM FINANCIAL EXPOSURE UNDER ANY OF THE REPORTED ARRANGEMENTS? IS IT POTENTIALLY GREAT ENOUGH TO INFLUENCE THE QUALITY OF CARE THEY DELIVER?
- MOST IMPORTANTLY, WHAT IS THE ACTUAL LINKAGE BETWEEN PHYSICIAN PAYMENT ARRANGEMENTS AND QUALITY OF CARE? IS THERE ANY DEMONSTRATED CORRELATION BETWEEN THESE TWO CONSIDERATIONS?

ANSWERS TO THESE QUESTIONS ARE NEEDED BEFORE MEANINGFUL "EXCEPTIONS" CAN BE IDENTIFIED.